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HEALTH SERVICES RESTRUCTURING COMMISSION

Hamilton-Wentworth Health Services Restructuring Report

November 1997

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INTRODUCTION AND BACKGROUND

The Ontario health services system is facing its single greatest challenge since the inception of medicare. Increasing demand, changing patterns of practice, and new technologies coupled with limited resources must be addressed if we are to maintain and enhance a health care system that is among the best in the world. We must streamline administration, reduce redundant capacity, and improve clinical services delivery to ensure efficient and effective use of resources and improved linkages between sectors. These are some of the steps necessary to restructure the current system effectively. Only when they are accomplished can a true health services system emerge that will be responsive to the future needs of the population into the next millennium.

In the seventies and eighties, the Hamilton community and in particular its hospitals, district health council, and university were viewed as leaders in hospital and health care restructuring. The amalgamation of the Henderson and General hospitals as well as the Chedoke and McMaster hospitals eliminated administrative waste and coordinated clinical activity to produce a more effective and efficient approach to health care delivery. Freestanding ambulatory care facilities were unheard of in Canada when the St. Joseph's Hospital conceived and implemented the Stoney Creek facility. St. Peter's Hospital introduced innovative ambulatory care programs for the chronically ill and elderly, like the "Easy Street" program. The Hamilton Psychiatric Hospital provided leadership in the diagnosis and treatment of the dual-diagnosed population; i.e. for patients with both mental health and physical health problems. Linkage with other mental health providers, both hospitals and community agencies, throughout the central west region was another area of development that the HPH launched. All of these initiatives are indicative of the forward-looking approach to the delivery of health care services in Hamilton-Wentworth.

Hamilton is also the newest academic health sciences centre in the province. McMaster University, through its medical faculty, health sciences division, and its economics faculty, continues to pioneer activity in a variety of academic fields, including the introduction of nurse practitioners, innovations in population health, and the work of the Center for Health Economics and Policy Analysis. Linkages between the local health care system and the university are strong.

Of course, in the seventies and eighties growth in the funding of health care services, hospital services in particular, exceeded either inflation or economic growth. Incentives to be innovative, particularly in addressing reduction of operating expenses, were few. This is in sharp contrast to the lower budgetary increases and reduced government funding that followed in the nineties, at a time when actual costs of providing hospital care were rising. This combination of circumstances provided the incentive for significant restructuring of service delivery system in order to meet increased service requirements within the resources available.

In 1996, the amalgamation of the Hamilton Civic Hospital with Chedoke-McMaster Hospital formed the Hamilton Health Sciences Corporation, one of the largest hospital mergers in Ontario in recent years. The merger improved alignment and consolidation of clinical services and trimmed administrative overhead expenses, better positioning the hospital for forthcoming reductions in Ministry funding allocations.

The St. Joseph's Health Care System was formed to take advantage of the synergy of service provision within denominational hospitals and other providers in the central west region of the province. Consolidation of a variety of administrative and support services reduced overall expenses in all participating organizations. Furthermore, clinical linkages between providers were strengthened providing a fuller continuum of care within the system.

Hamilton hospitals have seen the need for further restructuring to improve patient care delivery within reduced resources and changing demographics of the population in the years to come. Their realization led to planning by the Hamilton-Wentworth District Health Council (HWDHC) to address this exigency. The first consultation report of the exercise, *Comprehensive Health Care Plan*, called for fewer acute care sites with significant restructuring of clinical activities and roles played by various hospital sites.

By design, the DHC review and report addressed recommendations that were significantly broader than the hospital system, in recognition of the systemic requirements for health services delivery into the future. As in other communities, the DHC recognized the need for fundamental change. The linkage between hospital and community services, and the need for formal collaboration between and among all sectors are key elements of the review.

The Hamilton-Wentworth health services system has proved both innovative and adaptable in response to changing circumstances whether dictated by the more limited availability of resources, changing population health service needs or both. This is a tribute to the leadership of the hospitals, university, district health council, physicians, community and other providers. Further restructuring is required in Hamilton to fulfill the promise of the earlier studies. This report will address the deliberations and conclusions of the HSRC with respect to health services restructuring in Hamilton-Wentworth and the other central west communities that its providers serve.

HSRC Mandate and Terms of Reference

Bearing in mind the magnitude of the task and the limited time and funds available, the HSRC will function in accordance with the following terms of reference.

1. To discharge its mandate, the HSRC will:
 - Make decisions on restructuring of hospitals, including the provincially operated psychiatric hospitals, by directing or recommending to the Ministry of Health hospital closures, amalgamations, program transfers and any other actions considered necessary to implement hospital restructuring.
 - Make recommendations to the Minister of Health on how to improve the efficiency and effectiveness, including cost-effectiveness, of other elements of the health services system while maintaining or enhancing the quality of services provided.
 - Identify areas for reinvestment in communities that will lead to the development of a comprehensive, integrated community, district and regional health system.
2. The HSRC's work plan will be undertaken quickly, meeting a schedule to discharge its mandate within four years.
3. Options for change will be evaluated against three broad criteria:
 - maintenance or enhancement of quality of services
 - maintenance or enhancement of accessibility to service, and
 - affordability.

The current need to rationalize, consolidate and better integrate health services in Ontario means that difficult decisions must be made about how to restructure the health care system. The goal is a system that continues to provide high-quality services to patients at a substantially reduced cost while becoming more fully integrated. This is one of the major assumptions underlying all of the Commission's deliberations.

In January 1997, the HSRC released a vision of what it believes the future health services system will look like. The vision describes a system that is characterized by improved integration and co-ordination, organized geographically but managed locally in concert with provincially developed policies, goals and objectives. It is a system that recognizes that constantly improving technologies and changing patterns of practice are reducing the need for institutional care even as demand increases for other levels of care, including community-based health services, because of changing demographics and consumer expectations.

As a working hypothesis the vision statement is intended to provide a context for our restructuring decisions and recommendations, and to stimulate broad public discussion that will help to refine the health services system.

Historically, health care has been a fragmented sector. In fact, the difficulties of the current care “non-system” have been well-recognized: “silos” of funding, structure and policy tend to build rigidity and fragment care. Government policy and funding envelopes for example, can contribute to the placement of patients in levels of care that they do not require and deny them easy access to those they do. They can also frustrate new initiatives and services that offer better alternatives to the status quo. The HSRC believes that much of this fragmentation will be reduced with the current trend toward greater vertical and horizontal integration of providers and sectors into systems (described in our vision statement as integrated health systems -- IHSs) capable of offering the full continuum of care while shifting resources as appropriate to meet real needs.

While the HSRC believes that integration is essential to system-building, it also acknowledges the importance of diversity in each sector’s components. The objective is not to make all hospitals or long-term care facilities the same. Integration need not stifle diversity or distinctiveness, nor result in organizational consolidation. Integration does, however, require compromise, shared vision and values, and a willingness to pursue the common goal of improved health outcomes and health care. As integration is essential, so is diversity – an element that has been carefully considered in our review of the Hamilton-Wentworth health care system.

A high level of commitment and a high degree of change are needed to alter the current level of organizational and provider autonomy that will allow us to advance from today’s relationships to tomorrow’s integrated systems. While the HSRC has not underestimated the magnitude of this challenge it is equally aware that preserving the status quo is not in anyone’s interest.

The HSRC believes that the Notices of Intention to Issue Directions being released in Hamilton-Wentworth will allow the health care partners to proceed with a plan for a sustainable service delivery model. This model is characterized by a strong hospital system and a strongly integrated health system capable of meeting the future needs of the community within the financial resources available.

It is our hope that the changes for Hamilton-Wentworth, as outlined in the accompanying Notices of Intention to Issue Directions, will continue a process of coherent, constructive change, renovation and modernization.

The HSRC Process

The role of the HSRC is to make decisions about health system reconfiguration and restructuring based on three prime criteria: quality of care, accessibility to care, and affordability of care. Given the current fiscal environment, quality and accessibility will suffer if the status quo prevails. Sensible planning to restructure hospital and related services is the starting point. The major objectives of the HSRC are to ensure accessibility and high quality health care, to reduce expenditure on overhead and administration, to reduce duplication and redundancy, to focus resources on direct patient services and to reinvest in those areas where needs dictate. Perhaps more fundamental to its decision-making is the organization of health services to improve the critical mass and clinical coherence of programs and services to maximize benefits to patients and providers. Organizing and sizing services to improve accessibility are also cornerstones of HSRC decision-making.

A leading objective for the HSRC is to create a hospital system in Hamilton-Wentworth the components of which work co-operatively to provide the residents and the referral populations with the best services. At the same time this system must be set up to provide the foundation of an integrated health system to meet the health services needs of the region.

The HSRC has addressed issues of a regional nature such as long-term inpatient mental health services and the needs for inpatient rehabilitative services in the central west region.

As part of its review, the HSRC met with the Hamilton-Wentworth District Health Council and providers. The HSRC is encouraged by the degree of co-operation among the various stakeholders and commends the providers and the community for the commitment of their partnership to restructure.

Site visits were conducted in June 1997. HSRC members met with residents, administrators, board members, physicians, professionals, labor representatives and others in an effort to better understand the issues affecting and interrelationships among the Hamilton-Wentworth hospitals and other health services in the region.

As in other centres, the HSRC has made its recommendations based on the best available data and analysis, community input and recommendations, never losing sight of its three primary criteria of quality, accessibility and affordability of health services.

Updating the data, analysing the information, and assessing the available options are major activities undertaken by the HSRC as part of its decision-making process.

The HSRC's decisions recognize and address the particular aspects of the Hamilton-Wentworth health care system and its leadership role in serving the needs of the central west Ontario community. The decisions are focused on the development of a

hospital system that will serve the needs of Hamilton-Wentworth for years to come. To this end the recommendations for a “restructured” hospital system take into account the expected population growth rate for the region to 2003.

Purpose and Overview of the Report

This report contains the results of the analysis that the HSRC conducted as part of its review of the Hamilton-Wentworth hospital restructuring process and report. The lead commissioner involved in the review was Dan Ross. Dr. Maureen Law was an accompanying commissioner.

The results, decisions and directions to the hospitals are detailed in the following pages. While building on the work of the HWDHC, the HSRC has used the experience gained in other communities to strengthen the efficiency methodologies that will be applied to Hamilton-Wentworth and gain additional efficiencies.

To achieve the directions laid out in this report will require the dedication, commitment and hard work of all stakeholders. The recommendations balance quality, accessibility and affordability in a comprehensive approach to the future configuration of the health care delivery system in Hamilton-Wentworth.

The structure of the report is as follows:

- **Section I** provides a regional and community profile of Hamilton-Wentworth and includes key demographic, health status and socio-economic data related to the population.
- **Section II** provides a broad overview of the current health care delivery system and an analysis of costs, clinical/utilization rates and supply requirements.
- **Section III** provides summaries of the Hamilton-Wentworth District Health Council’s deliberations.
- **Section IV** outlines the framework and decision criteria for assessment of options that the HSRC considered during its review process.
- **Section V** outlines resource requirements to 2003.
- **Section VI** gives an overview of facilities assessment.
- **Section VII** details acute care requirements and proposed changes.
- **Section VIII** details non-acute care requirements and proposed changes.
- **Section IX** outlines governance and management changes.
- **Section X** outlines long-term care requirements.
- **Section XI** outlines the capital investment requirements for the preferred option, and the reinvestment requirements to lessen the effects of restructuring and address gaps in current services.
- **Section XII** outlines the summary of the HSRC’s decisions and intended directions.

SECTION I: COMMUNITY PROFILE

Geographic Profile

The City of Hamilton is located in the Hamilton-Wentworth Region which is bounded by Niagara Region to the south, Brant County to the west, Wellington-Dufferin County to the north and Halton Region to the east. It is one of seven counties in central west Ontario. The city of Hamilton is situated on the Niagara escarpment, which serves as a natural boundary in Hamilton. Areas in Hamilton on top of the escarpment are referred to as being 'on the mountain'. Access between the rest of Hamilton and the mountain is described by some as potentially problematic, particularly during the winter. Most of the new growth in Hamilton is projected to occur on the mountain. This is illustrated in the graph in appendix A (*population change by FSA in the Hamilton area 1995-2003*).

Resident Population

The 1995 population of Hamilton was 497,172 or about 23% of the population of central west Ontario.

Based on Ministry of Finance projections, between 1995 and 2003, the population of Hamilton-Wentworth is expected to grow by 12.3%. In the same period, the central west region population will grow by 14.1%, as compared to the provincial forecast of 12.7%.

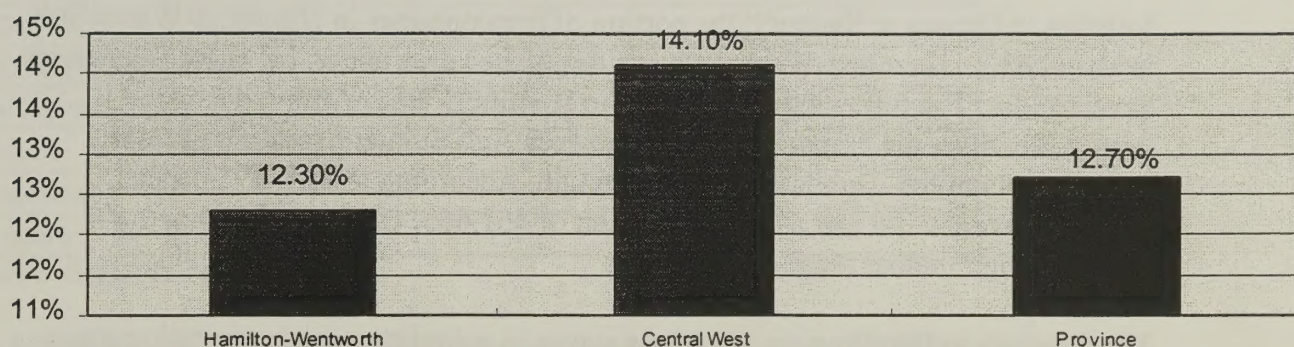
Table 1: Population Projections 1995-2003

Year	Hamilton-Wentworth	Central West Region	Province
1995	497,172	2,169,177	11,133,478
2003	558,465	2,477,423	12,534,572

Source: PDST (1) ¹ & Ministry of Finance population projection, 1992-2021

¹ The Planning Decision Support Tool (PDST) is a spreadsheet-based software application intended to assist in the analysis and review of program-related projects and to assess hospital utilization performance against provincial targets, average and benchmark performance levels in key categories of hospital activity. The PDST is made up of a variety of databases used by the Ministry of Finance. These include: Canadian Institute for Health Information acute patient separation abstracts; hospital annual MIS trial balance: statistical returns; Government of Canada 1991 census; Ministry of Health population projections; and short stay analysis system, hospital referral population calculations, mental health statistics, inventories. and other Ministry data systems

Percent Change in Population 1995-2003



The population projections for Hamilton-Wentworth to 2003 show a higher overall projected increase in the 0-14 years age group and the 75+ age group than the provincial average.

Table 2: Growth by Age Group for Hamilton-Wentworth & Ontario: 1995- 2003

AREA	YEAR	0 - 14	15 - 44	45 - 64	65 - 74	75 +	Total
Hamilton-Wentworth	1995	99,005	227,463	102,344	41,105	27,255	497,172
	2003	107,996	240,955	130,628	40,509	38,377	558,465
		9.1%	5.9%	27.6%	-1.4%	40.8%	12.3%
Ontario	1995	2,252,105	5,224,671	2,311,926	801,170	544,058	11,133,930
	2003	2,408,435	5,521,852	2,999,112	853,950	751,691	12,535,040
		6.9%	5.7%	29.7%	6.6%	38.2%	12.6%

Source: Ministry of Finance population projection, 1992-2021

Referral Population

The referral population is the number of persons, regardless of where they live, who receive care in Hamilton-Wentworth Region. Referral population is assigned to a hospital, based on a relative share of inpatient separations (i.e., discharges, transfers, deaths, sign-outs) for a given county/region attributable to that hospital. In 1995, the referral population of Hamilton-Wentworth was 605,342 compared to the resident population of 497,172. This indicates that the region's hospitals serve a significant number of residents from surrounding communities.

Relative to Ottawa or Sudbury, the portion of francophones in Hamilton-Wentworth is low (1.8%). Hamilton-Wentworth is a designated area under the French Language Services Act. The following towns/cities in Hamilton-Wentworth have been

population of 497,172. This indicates that the region's hospitals serve a significant number of residents from surrounding communities.

Relative to Ottawa or Sudbury, the portion of francophones in Hamilton-Wentworth is low (1.8%). Hamilton-Wentworth is a designated area under the French Language Services Act. The following towns/cities in Hamilton-Wentworth have been designated under the French Language Services Act: Stoney Creek, Glanbrook, Ancaster, Hamilton, Dundas and Flamborough. According to the 1991 census, Hamilton-Wentworth had a total population of 451,665. Of these, 8,090 or 1.8% indicated their mother tongue was French.

The hospitals in Hamilton are at various stages in submitting implementation plans for the provision of French language services to the district health council for review and comment.

The HSRC intends to direct the hospitals to work together to develop and implement a plan regarding French language services in hospitals, to submit to the Hamilton-Wentworth District Health Council. The HSRC considers the issue of access to French language services to be very important and directs both St. Joseph's Hospital and Hamilton Health Sciences Corporation to develop plans to describe which services they intend to be designated and available in French.

Inflow/Outflow Analysis

The net inflow/outflow is the difference between the utilization of inpatient acute hospital services by county residents and the provision of these services by county hospitals. Table 3 shows that 26% of the separations from Hamilton hospitals were from outside the region. These patients used Hamilton hospitals for a range of secondary and tertiary services such as cardiovascular surgery, neonatology, trauma and major cancer procedures.

*Table 3: Net Inflow to Hamilton Hospitals for Inpatient Activity (1995-96)**

	Separations	% of Total	Days	% of Total
Total Hamilton-Wentworth patients	47,385	73%	500,232	74%
Total from other jurisdictions	17,542	27%	171,997	26%
Total of above	64,927	100%	672,229	100%

*Source: S60- 1995-96 *(excludes newborn, acute psychiatric and non-Ontario residents)*

Table 4: Usage of Hamilton Hospitals by Residents of Central West (1995-96)

County of Residence	% Days
Hamilton-Wentworth	95%
Brant	2%
Wellington-Dufferin	1.4%
Haldimand-Norfolk	3%
Halton	4%
Waterloo	2%
Niagara	6%

Source: S60-1995-96

As table 4 shows, a majority of Hamilton patients get their care in Hamilton. Since Hamilton is an academic health sciences centre, it is a regional referral source for the surrounding areas such as Haldimand-Norfolk, Brant, Niagara and Halton regions.

Health Status Profile

Standardized mortality rates, proportion of low birth weights and infant mortality rates are some of the health status indicators used to gauge a community's health status.

Table 5: Standardized Mortality Rates For Selected Categories Hamilton-Wentworth

Standardized Mortality Rates ²					
Selected Categories	1992	1991	1990	1989	1988
Infectious Disease	1.1	1.06	0.96	1.1	1.26
Neoplasm	0.95	1.06	0.96	1.1	1.26
Mental Disorders*	1.18	0.79	0.75	0.91	1.03
All Ischemic Diseases	1.17	1.19	1.12	1.09	1.16
Circulatory System	1.1	1.12	1.04	1.06	1.13
Respiratory Disease	1.01	1.13	1.04	1.06	1.13
Genitourinary Diseases	1.3	1.14	1.29	1.41	1.26
Digestive Diseases	1.19	1.14	1.29	1.41	1.26

**Rates are standardized so that the Ontario average equals one. Source: Public Health Branch, Ministry of Health*

² Standardized mortality rates (SMR) are used when comparing mortality and morbidity of a district with that of the province. This statistic is a ratio of the observed total rate in the area over the expected total rate of the province.

Table 6: Standardized Mortality Rates

Year	Standardized Mortality Rates All Causes-Hamilton-Wentworth
1992	1.03
1991	1.07
1990	1.04
1989	1.05
1988	1.04

Source: MOH

The mortality indicators shown in the above tables suggest:

- Relative to the province as a whole, mortality due to heart disease is high in Hamilton-Wentworth. Researchers suggest that the higher rates for heart disease may be linked, in part, to the smoking, eating and exercise habits of the population.
- Mortality due to genitourinary and digestive diseases is particularly elevated compared to the provincial rates.
- Relative to the province, mortality due to mental disorders over the five year period noted is lower for Hamilton-Wentworth.
- Hamilton-Wentworth has a slightly higher overall standardized mortality rate than the provincial average.

Infant Mortality and Low Birth Weight

The percentage of low birth weight babies is an indicator of the level of both maternal and infant health. It also reflects the level of general reproductive health in a community.

In the final year of available data, the low birth weight rate for Hamilton-Wentworth is higher than the provincial average. The infant mortality rate for Hamilton-Wentworth fluctuates from year to year, largely due to smaller numbers at the county level.

Table 7: Infant Mortality (per 1,000 live births) and Low Birth Weight

Hamilton-Wentworth	1993	1992	1991	1990	1989
Infant Mortality Rate	6.83	4.53	4.91	8.91	6.4
% Low Birth Weight	6.59	5.96	6.42	6.11	5.67
Ontario					
Infant Mortality Rate	6.42	5.88	6.28	6.27	6.78
% Low Birth Weight	6.15	5.55	5.58	5.38	5.32

Source: Mortality and Morbidity Reports, Ministry of Health

Socio-Economic Indicators

The socio-economic profile of Hamilton residents differs from that of Ontario as a whole: there is a higher proportion of residents with less than grade 9 education and a higher proportion of people earning low incomes.

Table 8: Socio-Economic Indicators

Indicators	Hamilton	Ontario
Unemployment Rate	9.8%	8.5%
Labor Force Participation Rate	66.2%	69.6%
Less than Grade 9 Education	13.6%	11.5%
Prevalence of Low Income	14.8%	10.9%
Mother Tongue Other than English or French	19.0%	17.7%

Source: Statistics Canada, 1991

In summary, a review of demographic, health status, and socio-economic indicators reveals Hamilton-Wentworth unemployment rates are higher, average family income is lower, and measures of health status such as low birth weights are less favorable than those of the province overall.

These data should not be viewed as indicators of the appropriate level of resources, utilization of services or need. They are provided strictly for comparative purposes and should not be assessed in isolation from a more complete analysis of the region's health system.

Health Expenditures

A comparison of overall provincial health expenditures for Hamilton-Wentworth region, Metro Toronto and the province suggests that, on a per capita basis, the level of funding is similar to Toronto and higher than in other areas in Ontario. One reason for this discrepancy could be Hamilton's role as a major referral centre for tertiary care in central west Ontario which, as noted earlier results in a 27% inflow of patients to Hamilton hospitals. The per capita expenditure in mental health is almost double the provincial average and more than double that of Toronto. This may be a reflection of a higher proportion of elderly people in Hamilton and of the presence in Hamilton-Wentworth of a provincial psychiatric hospital.

Table 9: Comparison of Health Expenditures (Per Capita, 1993/94)

	Ontario	Hamilton Wentworth	Metro Toronto
Health Expenditures	\$1,551	\$2,147	\$2,157
Hospital & Related Facilities	\$718	\$1,118	\$1,049
OHIP Expenditures	\$449	\$532	\$714
Long-Term Care*	\$178	\$197	\$163
Mental Health Services	\$65	\$105	\$50
Drug Programs	\$89	\$108	\$108

**Includes Extended Care, Home Care Assistance, and Placement Co-ordination Services*

Source: Ministry of Health

SECTION II: OVERVIEW OF THE CURRENT HEALTH SYSTEM IN HAMILTON

Overall Health Services

Hamilton-Wentworth has a multitude of wide-ranging health services including:

- more than 1,000 practising physicians
- three community health centres
- a department of public health
- the Community Care Access Centre (CCAC)
- homes for special care
- mental health group homes
- 14 nursing homes with a total of 1,520 beds
- four homes for the aged with a total of 959 beds.
- a regional cancer centre
- a provincial psychiatric hospital
- a chronic care hospital
- 37 health service organizations
- 47 independent health facilities
- two acute care hospitals on five sites (one ambulatory care site)
- several walk-in clinics and other health care services

Hospital Services

Overview of the Hospitals

There are two acute care teaching hospitals operating on five sites in Hamilton: the Hamilton Health Sciences Corporation and St. Joseph's Hospital.

The Hamilton Health Sciences Corporation (HHSC) was formed in November, 1996 as a result of amalgamation of the former Chedoke-McMaster and Hamilton Civic hospitals. The HHSC operates on four sites:

- The **General** site is located in the centre of the city, with a focus on tertiary referral services including multiple trauma, adult neurosurgery, cardiovascular surgery and burns.
- The **Henderson** site is located on the central mountain and is the host hospital for the regional cancer centre.
- The **McMaster** site is located in the west end and houses the regional paediatric program.
- The **Chedoke** site is located on the west mountain and provides continuing care and rehabilitation services.

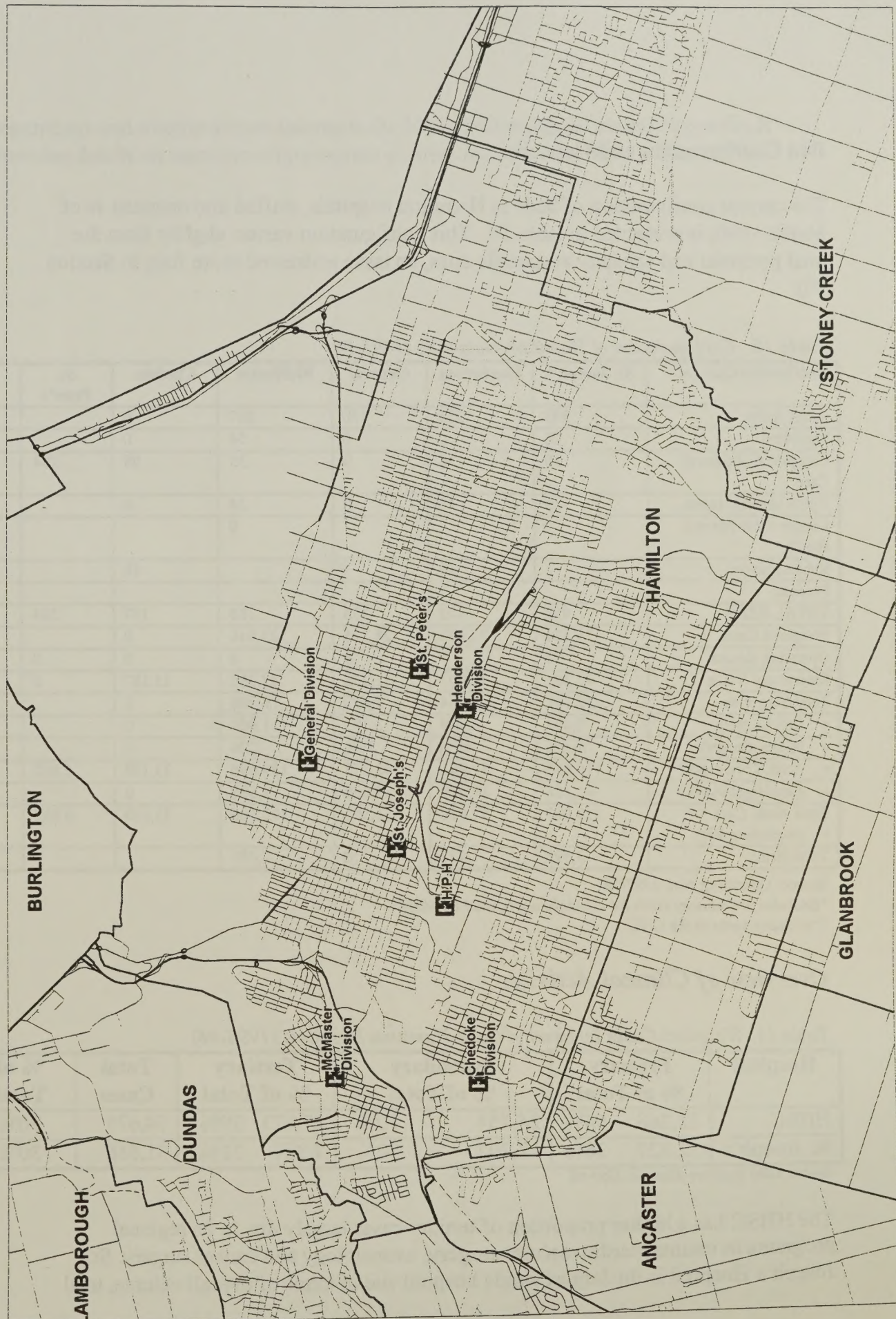
St. Joseph's Hospital operates a large hospital in downtown Hamilton, with a focus on respirology, nephrology, head and neck surgery and rheumatology. It also operates a community health centre located in the east end of Hamilton.

St. Peter's Hospital is located in the central east part of the city and is a dedicated chronic care and rehabilitation facility.

The Hamilton Psychiatric Hospital is a provincial psychiatric hospital located on the mountain.

Locations of hospitals in the Hamilton-Wentworth district health planning region are shown on the map following.

LOCATION OF HOSPITALS IN THE HAMILTON AREA



Bed Configuration and Capacity

The current configuration of beds in Hamilton hospitals, staffed and operated as of March 1996, is presented in table 10. This configuration varies slightly from the total potential bed capacity at specific sites, an issue addressed more fully in Section VII.

Table 10: Configuration of Hamilton Hospitals (1995-96)

Bed/Service Category	St. Joseph's	Henderson	General	McMaster	Chedoke	St. Peter's	HPH
Adult Acute	385	323	330	267	0		
Paediatric	28	0	0	54	0		
Complex Continuing Care	30	38	0	35	98	284	
Acute Mental Health	33	26	0	24	0		
Longer Term Mental Health				0			193
Rehabilitation		39	0		89		
Forensic							18
TOTAL BEDS	476	426	330	380	187	284	211
Weighted Cases	31,854	22,420	28,315	23,940	0		
Operating Rooms	16	7	8	8	0	0	0
Emergency Visits	47,361	31,907	36,233	32,360	15,587	0	
Total Surgeries	15,701	8,034	9,427	16,708	0		
• Day Surgery	8,893	3,869	3,397	11,968	0		
• % Day Surgery	56.6%	48%	36%	72%	0		
• Amb. Care visits*	116,635	37,991	42,275	189,698	33,130	5,852	28,248
• Day/Night visits *	41,258	19,029	9,030	3,668	0		
Total Amb. Care **	158,063	57,020	51,305	193,366	33,130	5,852	28,248
• (excluding ER)							
Total births	3,590	1,477	0	1,457			

Source: Operating plan 1997/98

*Excludes ambulatory visits for Chedoke not funded by MoH.

**excludes visits to the CHC

Overview of Clinical Activity

Table 11: Weighted Cases by Level of Care-Hamilton Hospitals (1995-96)

Hospital	Primary % of Total		Secondary % of Total		Tertiary % of Total		Total Cases	% of Total
HHSC	22,268	64%	24,734	70%	27,673	79%	74,675	70%
St. Joseph's	12,327	36%	12,202	30%	7,327	21%	31,856	30%

Source: CIHI Inpatient Abstract, 1995-96

The HHSC has a higher proportion of tertiary cases largely due to its regional programs in trauma, cardiovascular surgery, neonatology and cancer surgery. St. Joseph's Hospital is the largest single hospital site in terms of overall volume, total

separations and weighted cases (accounts for 30% of all weighted cases).Appendix B provides details on separations by program clusters for both hospitals in Hamilton.

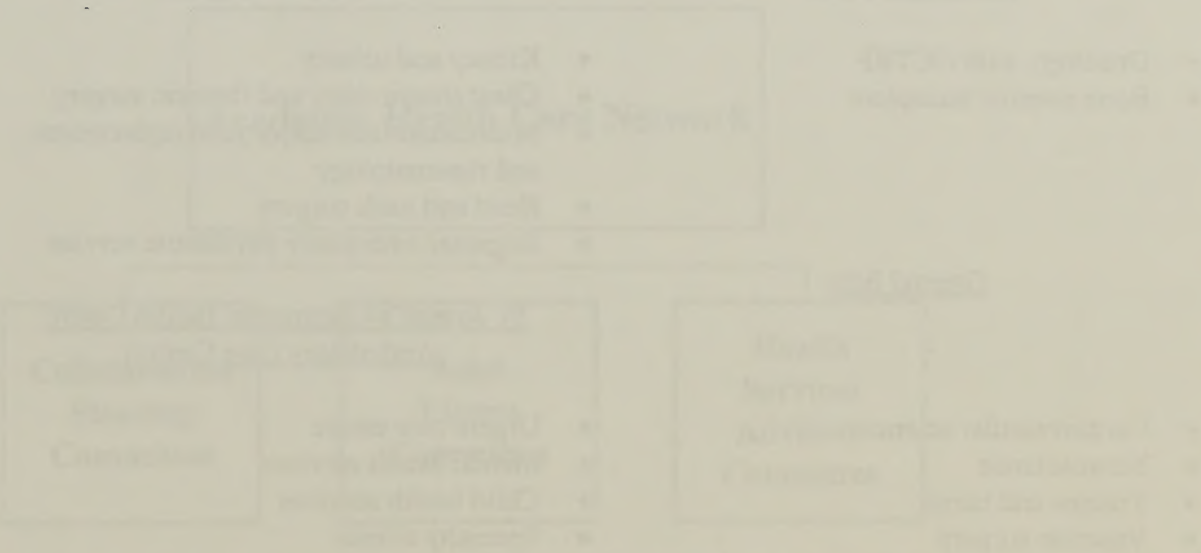


Table 12: Acute Separations, Patient Days and Weighted Cases, Hamilton Acute Hospitals

Hospital	Separations	%	Patient Days	%	Weighted Cases	%
St. Joseph's	22,690	35.8	148,302	31.8	31,856	30%
HHSC (three acute inpatient sites)	40,766	64.2	319,302	68.2	74,675	70%

Source: CIHI Abstract, 1995-96

Current Program Components

The following summarizes the current major program components of the Hamilton hospitals. Many of the tertiary care and regional programs are already rationalized.

Hamilton Health Sciences Corporation

Henderson Site

- Oncology with OCTRF
- Bone marrow transplant

General Site

- Cardiovascular sciences
- Neuroscience
- Trauma and burns
- Vascular surgery

McMaster Site

- High risk obstetrics
- Children's Hospital for central west
- Neonatal ICU
- In-vitro fertilization
- MRI and PET

Chedoke Site

- Acquired brain injury
- Child and adolescent psychiatry
- Specialized rehabilitation
- Host hospital for the regional geriatric program

St Joseph's Hospital

Charlton Ave. Site

- Kidney and urinary
- Chest (respirology and thoracic surgery)
- Musculoskeletal-major joint replacement and rheumatology
- Head and neck surgery
- Regional emergency psychiatric service

St. Joseph's Community Health Centre (Ambulatory Care Centre)

- Urgent care centre
- Mental health services
- Child health services
- Specialty clinics
- Geriatric services

St. Peter's Hospital

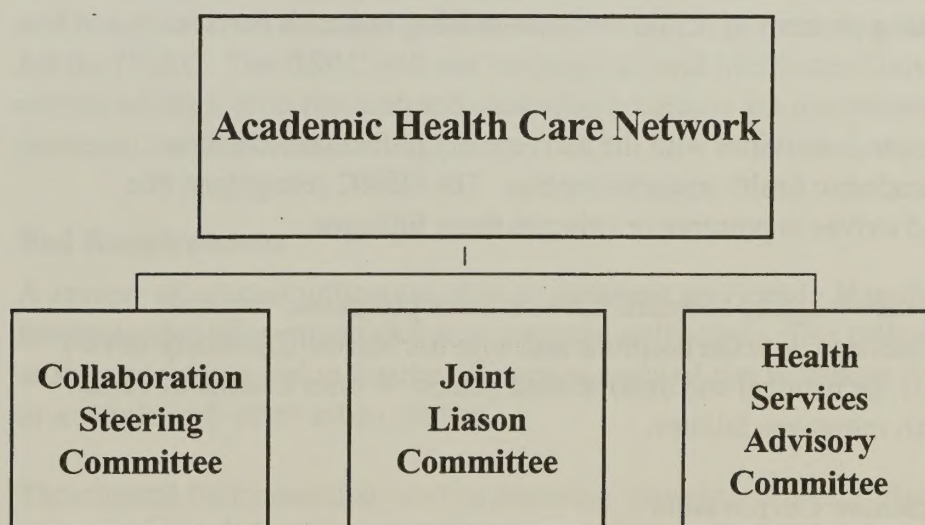
- Continuing care
- Rehabilitation
- Palliative care

Hamilton Psychiatric Hospital

- Long-term psychiatric patients

Academic Medicine (Research and Education) Activities

Education and research activities, as in other academic health sciences centres, are intertwined with the clinical activities of all of the hospitals in Hamilton-Wentworth. Together with the McMaster University Faculty of Health Sciences, Mohawk College Faculty of Health Sciences, the OCTRF Hamilton Regional Cancer Centre, Family Medicine Hamilton-Wentworth Association, and the Community Care Access Centre, the hospitals formed the Academic Health Care Network. This is an indication of the tradition of cooperation, collaboration and regional health services planning in Hamilton-Wentworth. There are three working committees associated with the Network. The Network relates to the regional municipality and the Hamilton-Wentworth District Health Council among other organizations engaged in health and social services planning and delivery.



The Network has been instrumental in the introduction of initiatives to reduce costs while maintaining and enhancing patient care. Included among these initiatives are:

- coordination and consolidation of support services
- clinical utilization improvements including current work on common evidence based clinical pathways
- coordination of services between members

The degree of integration of the McMaster Faculty of Health Sciences into the health care system is evidenced by the initiatives it has championed over the years. A key example is its involvement in the Hamilton Regional Laboratory Program. The Faculty through the Joint Liason and Health Services Advisory committees, is involved in the ongoing development of clinical programs which are regional in scope.

As noted earlier, the Faculty has had a long-term commitment to evidence-based practice and population health, both of which have earned it wide-spread national and

international recognition. In addition to these areas, the Faculty together with St. Peter's Hospital have developed prominent education programs and research into aging and health. Its efforts in respirology through the Regional Respirology Program at St. Joseph's Hospital are also nationally renowned particularly for the services to asthma patients. Also noted earlier, the work of the hospitals and the Faculty in mental health is also renowned especially in the coordination of services and the development of outreach services throughout the region.

Through affiliations with both McMaster University and Mohawk College, the hospitals provide clinical placements for students in a variety of health disciplines including medicine, nursing, social work, physiotherapy, occupational therapy, pastoral care and communicative disorders.

The availability of a critical mass of patients and facilities to engage in education activities is also a strong element of HSRC decision-making in health services restructuring.

The integration of research activities with the delivery of clinical services is a common feature of academic health sciences centres. The HSRC recognizes this important linkage and strives to preserve or enhance these linkages

Both Hamilton acute care teaching hospitals have research programs. Several research institutes associated with the hospitals and with McMaster University have competed successfully for national and international grants. A brief outline of some of their major research initiatives follows:

Hamilton Health Sciences Corporation

The HHSC has numerous major areas of research.

- The Hamilton Civic Hospitals Research Centre with research foci in:
 - arteriosclerosis and thrombosis
 - clinical trials methodology
 - preventive cardiology and therapeutics
 - thrombophilia in children

This foundation received \$12 million in external grants in 1995-96

- The HHSC has an intimate relationship with McMaster University in several areas:
 - Health Information Research Unit (piloted its Clinical Information Network CLINT on HHSC's clinical inpatient units)
 - Centre for Health Economics & Policy Analysis
 - HealNet
 - Education Centre for Aging & Health

- HHSC is a partner in Vascular Therapeutics Int'l, Canada which is involved in commercial marketing of new treatments.

St. Joseph's Hospital

- The Father Sean O'Sullivan Research Centre which had \$8 million in total grants in 1996
- The Clinical Effectiveness and Outcomes Research Program
- The Firestone Chest and Allergy Unit, largely responsible for ranking McMaster University as doing the second most influential respiratory research in the world
- The St. Joseph's Health Care System Research Network, focusing on aging and health services delivery.

HSRC recognizes the importance of research and education activities. Health research and hospital-based research and education are not, at present, specific areas of focus for the HSRC. The HSRC will ask the hospitals and McMaster University to ensure continued high level research and education programs are maintained as a result of the proposed hospital restructuring plan.

Bed Requirements

A review of current utilization of acute inpatient services in Hamilton-Wentworth hospitals identifies opportunities to improve utilization. The following analysis of acute separations and utilization illustrates some of the variances from the province as a whole and other urban centres.

The clinical benchmarking used in assessing potential clinical utilization improvements is based on best practices of Ontario hospitals by particular types of cases in most instances. In other circumstances, existing provincial policy is considered. In some instances, the best practices relate to 25% performance levels, while in others appropriate measures within the hospital sectors in Ontario are used e.g. 100% for ALC days.

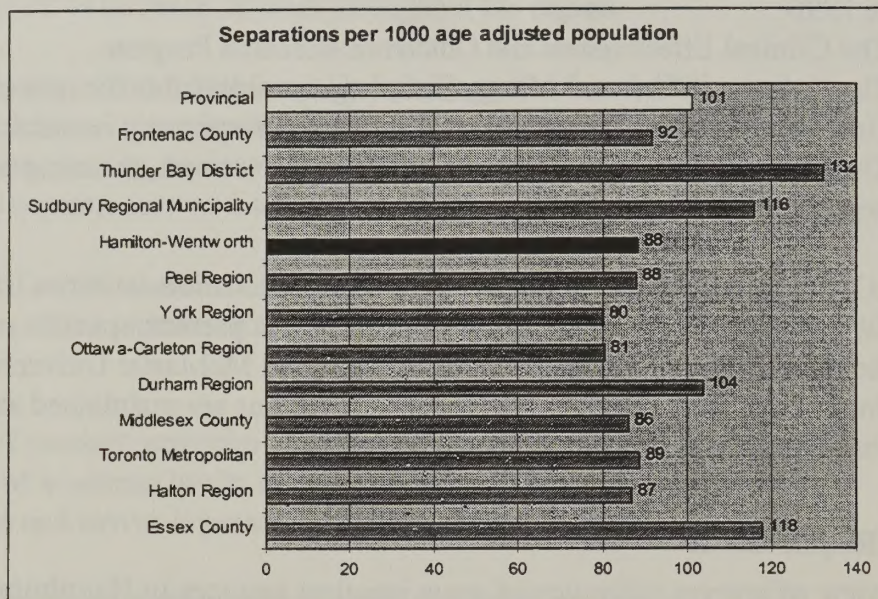
Acute Inpatient Utilization Analysis

The HSRC conducted comparative analyses of resource utilization to examine opportunities to improve the utilization of acute care hospital services. While the HSRC has not established a 'target rate' for utilization of hospital services, it is of interest to understand utilization of resources in comparative terms and make observations about opportunities to improve utilization of hospital services. Acute inpatient utilization can be measured in terms of separation and utilization rates. The HSRC has developed a model to compare those rates across the province and provide an indicator of the services currently being provided. While the model describes the rates for the province, for Ontario counties and regions, it does not indicate whether

those rates are appropriate or inappropriate; the HSRC makes use of the model as background information and as an indicator that further research may be necessary.

Separation Rates

Separation rates (i.e., hospitalization rates) provide a measure of the admission (or separation) activity of residents in various communities. The separation rates identified here are determined by



the number of separations in 1995/96 per 1,000 age-adjusted population (1996 Census)³. This rate is calculated before utilization improvements are considered, and is based on the population of Hamilton-Wentworth regardless of where they receive care. This rate will therefore differ from the ESI utilization rates of the hospitals which are utilized in later in this section. The methodology used to develop the age sex rates is described in further detail in Appendix C. The comparison across several counties shows Hamilton's separation rate is similar to all other health sciences centres, which are lower than the provincial average number of separations per 1000 population.

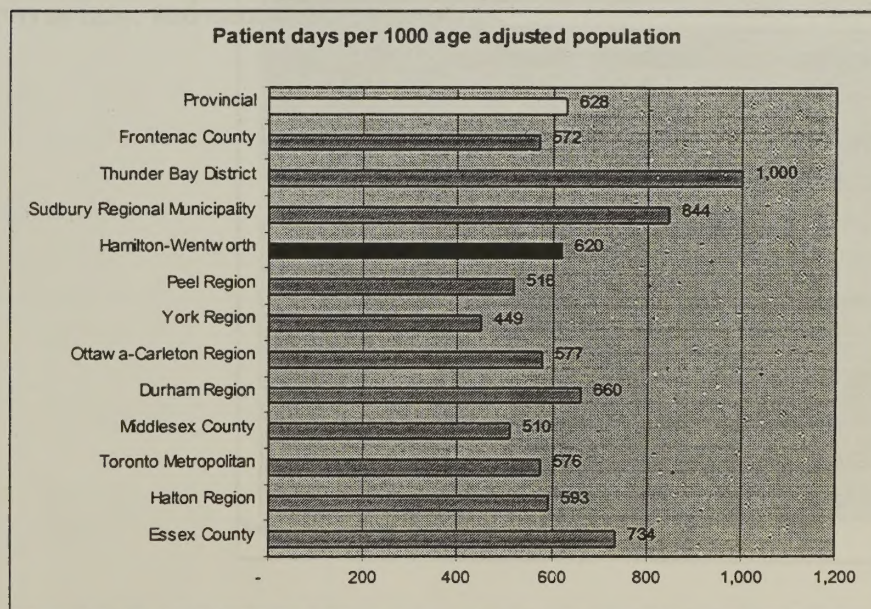
Initial analysis of admission (i.e., separation) rates indicated that the rates are related to a number of variables particularly the age and sex of the population being served. Standardizing the age sex rates with provincial rates explains a significant portion of the variation. Further analysis of the remaining variation is being undertaken by the HSRC. A clearer understanding of the variation in rates will be required if the

³ The separation rates illustrated differ from those shown in previous reports as the rates have been corrected to use recently released 1996 Census Canada population. The 1996 population as per Census is more accurate than using the 1995 Ministry of Finance projected population. Separation rates reported in previous HSRC report reflected Ministry of Finance projections based on 1991 Census.

province moves towards per capita funding models. The HSRC is undertaking further analysis to determine the relationship between hospitalization rates and factors such as health status, physician supply, socio-economic indicators and geography, all of which may help to explain why academic centres have lower admission rates than non-academic centres.

The methodology used by the HSRC in its restructuring of the health care system does not involve significant changes in separations in Hamilton-Wentworth or any other community. The conservable days associated with avoidable admissions (i.e., social/primary care admissions and ambulatory care indicated admissions) amount to less than 2% of total days provincially.

Utilization Rates



Examination of utilization rates considers the total utilization of hospital care by residents within a geographic area, irrespective of where services are accessed. This measure is calculated as total patient days for residents of the county/region

divided by the population adjusted for age and sex. The rates were calculated using 1995/96 patient days and 1996 Census population. The rates differ from those described in earlier HSRC reports : 1996 Census population data was used, since Ministry of Finance 1995 and 1996 population projections overestimated population growth) along with the age and sex adjustments to control for variation in age across communities. For 1995/96, the utilization rate for Hamilton was 620, slightly lower than the provincial average of 628 but higher than all the other four communities with health sciences centres.

The utilization rate is a function of two aspects of acute inpatient hospital use:

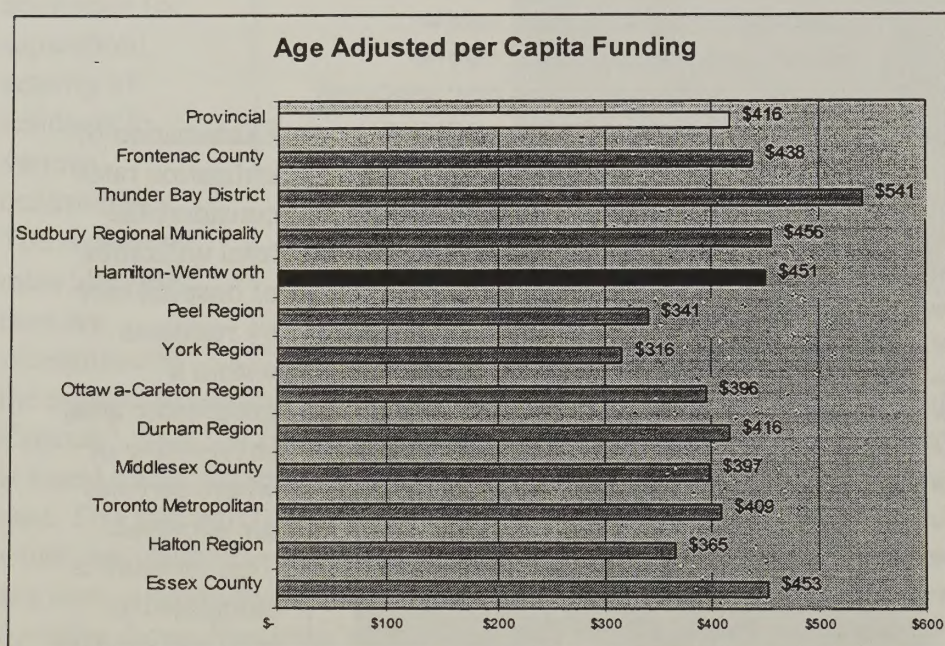
- the rate of hospitalization (separations)
- the average length of stay

In fact, an equation for the utilization rate may be written as follows:

$$\frac{(\text{Acute Separations} \times \text{Acute Average Length of Stay}) \times 1000}{\text{Population (number)}}^4$$

Since a hospital's utilization rate is driven by these two factors, hospitals need to ensure that utilization management strategies are in place that monitor and where possible improve both length of stay and appropriate admissions.

Per Capita Acute Care Expenditures



As in its Essex County and GTA reports, the HSRC undertook further study of the per capita funding for acute care services in Hamilton-Wentworth. The HSRC methodology accounts for acute care expenses attributable to county residents irrespective of where the care is delivered. The methodology does not reflect total hospital expenditures as it excludes ambulatory expenditures. However, it provides a perspective on the per capita funding consumed by the residents of the county. To accomplish this, direct standardization was used whereby each county's utilization rate was applied to the provincial population for the specific age and sex group and the results were compared.

⁴ The Acute Utilization rate can also be calculated by multiplying the hospitalisation rate (separations per 1000 population) by the Average Length of Stay.

As can be seen from the previous graph the per capita funding required for Hamilton is higher than that seen in other academic centres. This may be explained in part by the higher acuity level seen for patients treated in Hamilton hospitals.

All three of the previous charts, (age-adjusted separation, utilization rates and per capita funding) include days and cases that may be considered conservable under the methodology used by the HSRC. However, this data is useful in determining the overall impact of the HSRC methodology on the community. In Hamilton the age-adjusted separation rate of 88 per 1000 is similar to the rates of other academic centres. However, the age-adjusted utilization rate of 620 days per 1000 is lower than the provincial average but higher than that seen in other academic centres. The HSRC reaffirms its position of not setting a target (or minimum) standardized population-based utilization rate. Utilization patterns across communities and regions differ because of a wide range of factors, some of which include patterns of practice, acuity, average length of stay, geography, population characteristics, supply of physicians, and community resources.

SECTION III: HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL HEALTH SERVICES REVIEW

Mandate and Process

The Hamilton-Wentworth DHC established the Health Action Task Force (HATF), which conducted an extensive review of the current health care system in general and the hospitals in particular. Comprised of major stakeholders and community representatives, the HATF studied key areas such as:

- Governance
- Reconfiguration of acute care services
- Systems support
- Program rationalization (e.g. paediatrics, respirology, rehabilitation etc.)
- Education and research
- Primary care
- Integrated health system
- Rehabilitation
- Long-term care
- Emergency services
- Continuing care
- Mental health
- Facilities review

The HATF made 79 recommendations for changes in the above areas.

As part of its decision-making process, the DHC used several criteria including quality of care, affordability, teaching, research, future service needs, partnership and integration.

The DHC's report, *Comprehensive Health Care Plan*, was submitted to the Minister of Health in May 1996.

Key Recommendations of the HATF

Governance: HATF recommended that an integrated health services system be developed to plan, organize and co-ordinate overall changes proposed under the "Hamilton-Wentworth Systems Board", which would dissolve the DHC and other planning bodies in the region.

Number of Hospital Sites: The HATF recommended reducing the number of hospital sites from seven to five and reducing the number of acute sites from four to three. It also recommended that the following elements be located on the Chedoke site:

- a rehabilitation and chronic hospital governed by the Hamilton Health Sciences Corporation

- a tertiary mental health program governed by the Hamilton Psychiatric Hospital. The HATF also recommended the Hamilton Psychiatric Hospital be closed.

Primary Care: The HATF recommended that the urgent care centres located at Chedoke and St. Joseph's Health Centre (Stoney Creek) be maintained.

Rehabilitation: The HATF recommended that Chedoke take the lead in organizing rehabilitation services and in consolidating 100 beds at this site.

Mental Health: The HATF recommended that the existing number of acute and long-term psychiatric beds be maintained until effective community services are in place and until services are relocated from the Hamilton Psychiatric Hospital to the Chedoke site.

Long-Term Care: The recommendation was for adding 428 LTC beds.

Chronic Care: The HATF recommended that existing number of chronic care beds be maintained but consolidated on two sites from the current five sites (St. Peter's site for adults, Chedoke site for younger adults).

The HATF report indicated annual operating savings of \$75.5 million or 10.8 % of the 1994-95 operating budget. The estimated capital cost was \$83.2 million for the acute care sites, over \$111 million for Chedoke and \$20.7 million for St. Peter's site for a total of \$214.9 million.

Reactions to the HATF Report

Recommendations of the Hamilton-Wentworth DHC Regarding the HATF Report

The Hamilton-Wentworth DHC accepted most of the 79 recommendations of the HATF report. However, it did not accept the recommendations of the HATF regarding acute care. The DHC agreed to the following with respect to acute care and total number of sites:

- Reduce the number of hospital sites from seven to six.
- Maintain four acute care sites, three of which are full service acute sites, with four emergency rooms.
- The DHC supported the closure of the Hamilton Psychiatric Hospital. It urged care be taken in relocating its programs, and did not identify any specific sites.

Academic Health Care Network

The partners of the Academic Health Care Network (AHCN) made up of all area hospitals, Victorian Order of Nurses (VON) and McMaster University's Faculty of

Medicine, reviewed the HATF report and supported most of the recommendations except for the proposal dealing with inpatient care. The AHCN recommended three full-service acute care sites and a special focus acute care site with oncology as its main focus (Henderson site left with 160 beds).

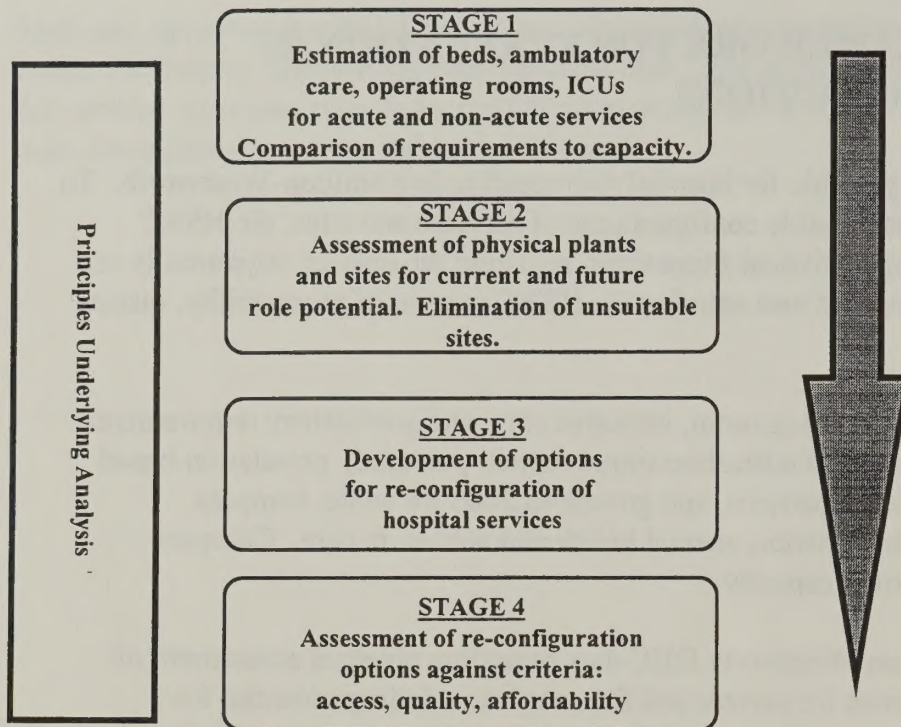
SECTION IV: FRAMEWORK FOR EVALUATION OF RESTRUCTURING OPTIONS

There are a number of possible for hospital restructuring in Hamilton-Wentworth. To logically assess the best possible configurations of services and sites, the HSRC developed the following analytical framework, reducing the options sequentially in order to arrive at the one that best satisfies the HSRC criteria of accessibility, quality and affordability.

1. Estimate total bed, operating room, intensive care, and ambulatory requirements through the assessment of utilization improvement potential, population-based planning ratios, referral patterns, and growth to 2003 for acute, complex continuing care, rehabilitation, mental health and sub-acute care. Compare requirements to current capacity.
2. Review the Hamilton-Wentworth DHC data regarding physical assessment of current plants and sites for current and future roles including potential for upgrading or expansion and life cycle costs. Assess the potential to eliminate plants and sites where redevelopment potential is relatively low and life cycle costs are projected to be high, particularly where significant redevelopment is required just to maintain current activity.
3. Develop options for the configuration of hospital services considering quality (optimal critical mass and clinical coherence) and access to service delivery criteria.
4. Assess the reconfiguration options against the criteria of quality, access and affordability.

In addition to these four stages of analysis, a series of principles were developed to assist in the culling of possible options to arrive at the option that maximizes the assessment criteria. These principles are:

- Determine pragmatic, do-able solutions that result in the least amount of disruption to patients and service providers.
- Build on existing programs or specialty strengths rather than relocate a critical mass of clinical activity to enhance and develop smaller programs.
- Existing capacity will be optimized relative to populations served. The acute care locations will ensure that access to emergency services is maintained.
- The use of high quality facilities and functional sites will be optimized.



The criteria for assessment of reconfiguration options, as noted in stage 4 above are as follows:

Criteria For Assessment of Options

The following criteria are used by the HSRC to assess all available options for the siting of acute, chronic, rehabilitation, and mental health inpatient and outpatient services in the Hamilton-Wentworth system:

Acute Care
Evaluative Criteria
QUALITY
Critical Mass
Clinical Coherence
ACCESSIBILITY
Population Need
Service Requirements
Proximity
Patient Transfer
Tertiary/Specialized Programs
AFFORDABILITY
Clinical Efficiency
Restructuring Savings
Administrative Efficiency
Support Services
Consolidation
Capital Costs
Implementation Costs
Reinvestment

Quality

Two elements of quality are assessed: critical mass and clinical coherence.

Critical Mass

Critical mass refers to the level of program clinical activity that will maximize the efficiency and effectiveness of service delivery in terms of:

- maximizing effective outcomes
- allowing for concentration of specialized skills and expertise
- providing for appropriate levels of staffing for recruitment and retention
- minimizing overhead and indirect expenses

Clinical Coherence

Clinical coherence refers to the clinical relationships between different programs and services. Some considerations in assessing clinical coherence are:

- maximizing continuum of patient care requirements for a single episode of care
- providing for coordinated response to needs by variety of related services
- minimizing duplication
- reducing patient transfers between sites for related services.

Accessibility

Population need and service requirements are examined in order to locate the hospital services near the population being served.

Proximity of services is determined by an examination of the driving distances to the hospitals and the location of the population they serve.

Most people tend to use the hospital closest to them. This is particularly the case for emergencies, but less so for elective admissions. In spite of this tendency, no hospital in Hamilton shows a disproportionately highly concentrated pattern of referrals.

Tertiary/specialized programs are assessed to ensure access to specialized services, tertiary and quaternary care, particularly in the area of cancer services, neonatology and cardiovascular surgery.

Affordability

Clinical Efficiency

Consideration is given to the extent to which each option achieves clinical efficiencies derived from admission management, reduced ALOS and appropriate placement of ALC patients. Some of the efficiencies, particularly in acute ALOS reduction, depend on the availability of and access to complementary services in inpatient rehabilitation, chronic and mental health services.

Support Services Consolidation

Refers to the level to which each option achieves consolidation of support services including materials management, food services and clinical laboratories, which are the main focus of the HSRC analysis of savings potential.

Administrative Efficiencies

Refers to the level to which each option achieves administrative savings.

Restructuring Savings

Restructuring savings relates to the level of productivity and efficiency achieved by each option.

Capital Costs

Consideration is also given to the extent to which each option minimizes capital costs and restructuring implementation costs.

SECTION V: ESTIMATING RESOURCE REQUIREMENTS: DETERMINING CAPACITY REQUIREMENTS OF THE HOSPITAL SYSTEM

Table 13 summarizes the inpatient requirements of a reconfigured hospital system:

Table 13: Hamilton-Wentworth Hospital Inpatient Bed Requirements

Category	1995/96	1997/98	2003**	Number of Beds Variance from 1997/98
Acute Inpatient	1,387	1,155	1,060	(95)
Rehabilitation	128	127	146	19
Complex Cont. Care	485	444	269	(175)
Adult Acute Mental Health	83	83	91	8
LT Mental Health	193	193	124	(57)
Forensics	18	18	18	0
Child & Adolescent M.H.	-	-	17	17
Total	2,294	2,020	1,725	(295)
Operating Rooms	39		46	
ER Visits	163,448	156,574	192,366	28,918
Amb.Care Visits*	454,277	462,052	534,649	72,597

Source: 1997/98 and 1996/97 operating plans

*Excludes ambulatory care visits in Chedoke not funded by MOH

**HSRC benchmarked beds required for 2003

The sizing of the inpatient hospital system is based on a variety of methodologies for sizing of various types of hospital services. These methodologies are summarized in the succeeding chapters.

The variance between the HSRC planning estimate for year 2003 when compared to beds in use presently suggests a need for 295 fewer beds which represents a reduction of 14.6% once all clinical efficiencies and planning guidelines are taken into account.

Estimating Growth in Clinical Activity to 2003

As in previous HSRC reports, growth to 2003 was estimated using a method based on population growth, incidence of disease, proximity of population to the hospital and existing referral patterns. This approach shows 162 additional acute care beds are required by 2003 to serve the population requirements, bringing the total number of beds required by the year 2003 to 1,060.

Estimated growth in clinical activity levels does not affect the estimated savings arising from the HSRC methodology. Funding of additional operating rooms will be dealt with through prevailing methods of the Ministry of Health and is therefore not addressed in the HSRC methodology.

Operating Room (OR) Requirements

Currently the Hamilton hospitals have 39 operating rooms. There were 21,743 inpatient surgical cases and 28,127 day surgery cases performed in Hamilton hospitals in 1995-96.

The methodology that the HSRC used to estimate the potential number of ORs required is based on advice from an expert panel of surgeons with input from other professionals. The HSRC and this panel reviewed data from all hospitals that report OR procedure times to the Canadian Institute of Health Information (CIHI). The data were segmented into three hospital peer groups: teaching hospitals, community hospitals larger than 100 beds, and community hospitals smaller than 100 beds.

The OR caseload was split into three components: ambulatory, primary/secondary and tertiary. The estimated time for procedures and total operating room time was derived from the data reported to CIHI and is used to calculate the total hours required per year. The preliminary advice to the HSRC indicated that tertiary ORs should be scheduled for ten hours per day and all other for nine hours per day. These planning guidelines also call for the ORs to be operated 240 days per year to allow for statutory holidays, weekends and other closures. The methodology is still under development, particularly with reference to the times per procedure.

Table 14 shows the number of ORs required in Hamilton-Wentworth by levels of care in 1995/96.

Table 14: Estimates of Total Operating Room Requirements for Hamilton-Wentworth, 1995/96

	Ambulatory	Primary & Secondary	Tertiary	Total
Procedures by level of care	44,909	15,632	7,621	68,162
OR minutes required	2,100,723	1,954,000	1,295,570	5,350,293
Estimated OR requirements for Hamilton-Wentworth	16.3	13.6	10	39.9
Total required in 2003				46

Source: CIHI, 1995/96

Based on the HSRC methodology, Hamilton-Wentworth in 1995/96 would have required 40 ORs. When growth to year 2003 is considered a projected 46 ORs will be required. This number is intended as a planning guideline, and is used in determining the capital cost associated with the restructured hospital system.

Emergency Room (ER) Requirements

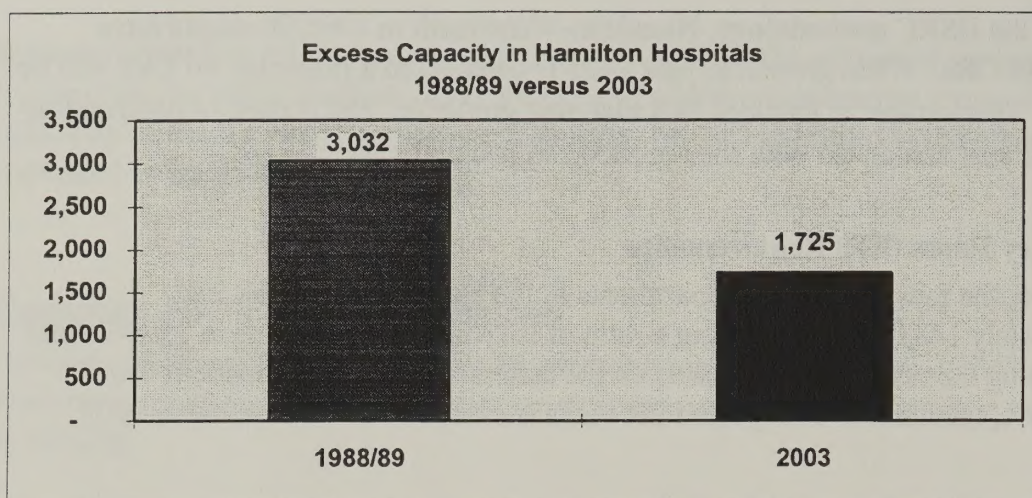
In 1995/96, the four emergency departments in the Hamilton hospitals had approximately 148,000 visits. Using a ratio of ER visits to acute beds in 1995/96 and extrapolating the results to 2003 based on the estimated growth in inpatient beds noted above, the number of expected ER visits is estimated to be 174,000 in 2003.

Ambulatory Care & Day/Night Visits

In 1995/96, the Hamilton hospitals had approximately 465,000 visits. Using a ratio of ambulatory visits to acute beds in 1995/96 and extrapolating the results to 2003 based on the growth estimate noted above, 501,000 ambulatory visits are expected in 2003.

Excess Capacity

As part of the HSRC analytical framework for the assessment of options, a comparison of projected bed requirements to the year 2003 with the current physical bed stock is necessary to determine whether there is sufficient capacity in the current hospital sites to accommodate the clinical activity. Where current capacity is higher than the required capacity the difference is considered in excess of requirements. The potential excess capacity for Hamilton-Wentworth hospitals was calculated based on the difference between the total number of beds in operation in 1988/89 compared with what is required by 2003. The difference is 1,307 beds or a 43% reduction in total beds. It is recognized that some of the 1988/89 capacity has been converted to other uses in the facilities and cannot be reconverted without further renovations. The 1,307 beds not used since 1988-89 are considered a proxy for excess capacity. The number of beds already closed was a key reason for the restructuring studies locally and it has a profound influence on the siting options under consideration by the HSRC in all communities.



**Acute beds include acute mental health beds*

Source: PDST 1988/89, HSRC Planning Guidelines 2003

SECTION VI: FACILITIES ASSESSMENT

The HSRC, using the expertise of its own facility assessment consultants, conducted an overall review of all hospital sites, based on material obtained directly from the hospitals. The studies undertaken by the DHC and the hospitals with respect to physical facilities assessment were also used to determine the suitability of sites for current or future roles. Each of the sites was assessed on the basis of the following dimensions:

- age of facilities
- potential of site to expand and/or accommodate renovation or new construction
- potential of the site to accept new roles
- life cycle costs (i.e., potential years of usefulness; replacement costs over next five, ten and 25 years)

An attempt was made to determine the relative rating of facilities based on available information. Much of the information was based on the 1996 DHC review and additional material sent by hospitals to the HSRC.

HHSC-McMaster Site

The McMaster hospital site is owned by the McMaster University and any redevelopment of the hospital site is subject to the University's master plan. The site is limited by existing university buildings and residential areas.

Completed in a single phase in 1971, the gross building area is 1.4 million square feet of which 40% is dedicated to medical school use. The main building is specifically designed for changing uses: it has a wide-span structure (75 feet) and accessible interstitial floors (engineering floors between the user floors).

Overall, the prime functional units, such as inpatient accommodation and the surgical suite are physically satisfactory and the building structure, fabric and systems are in good condition.

HHSC-Chedoke Site

The site is a campus of 200 acres of which 120 acres is available for development. Chedoke is a campus style hospital, consisting of 29 buildings which span a construction period of 1912 to 1987. The hospital portion of the buildings has 535,240 sq. ft. of space and an additional 132,000 sq.ft. are leased from the hospital.

In any renovations scenario there will be problems associated with older buildings, limited live load capacity, low floor-to-floor heights and issues of long-term deterioration. Functions have been fitted to the space and its limitations. A variety of

loosely related or unrelated activities are housed together including continuing care and rehabilitation, children's services (excluding inpatient and acute paediatric care) and dietary production for Chedoke/MUMC. There is also a growing inventory of unused and underused space with the prospect of more to be vacated.

HHSC-Henderson Site

The Henderson site is a campus of 13 buildings plus two garages. These buildings range from the 20 Wing, constructed in 1915, to the most recent research/materials management building, constructed in 1993. The entire facility comprises 660,500 gross sq. ft. The core hospital is generally in need of functional and system upgrading. This includes the inpatient accommodation, and particularly the ICU/CCU, surgical suite and imaging. The hospital is in the final stages of commissioning a new boiler plant to service the entire campus. Future expansion is not significantly restricted by the zoning bylaw. There is also upward expansion capacity on a number of wings.

The Regional Cancer Centre is located at this site and was completed in 1992 at a construction cost of \$31 million, and a total project cost of about \$41 million. There is also a Cancer Lodge of some 22,000 square feet.

Overall, the buildings on this site have potential for future use.

Hamilton General Hospital

The Hamilton General site is also owned by the City of Hamilton and consists of four major buildings of varying ages from 1949 to 1988. There have been many upgrades made to these buildings. The site is approximately 509,000 sq. ft.

Overall structure, fabric and systems are generally in good to excellent condition. Patient care areas are of contemporary design. Future expansion is not significantly restricted by zoning bylaw and, as of right, considerable expansion could be undertaken.

St. Joseph's Hospital

The hospital occupies a site of 18 acres, and has seven wings with 771,790 gross square feet. About 69% of the built area dates from 1961 or earlier. The remaining 31% was constructed in 1988-89. There have also been significant renovations to the older buildings for particular functional units such as dialysis.

The core hospital activity is housed in the 1961 and 1988-89 structures. Even the older accommodation is in good condition, and remains functional despite its age.

There is unused or readily available capacity in a number of areas such as ICU, laboratories and emergency. Development options are likely available on sites adjacent to the property. Overall, the structure, systems and fabric are generally in good condition.

The hospital also operates the Community Health Centre at Stoney Creek, constructed in 1991, which provides a further 88,000 square feet of modern ambulatory care space. Horizontal expansion of this building is possible.

St. Peter's Hospital

The hospital occupies 5.6 acres and has a gross building area of 186,000 square feet of which nearly 80% dates from 1974. The south wing (including resident units) is identified as being in need of replacement, for which plans are already prepared. The structure of the 1974 wing is structurally sound but does not conform to present fire codes. It may need to be fire-protected if a major renovation were contemplated. External envelope has some problems that require maintenance/replacement attention.

The buildings on this site were designed for a long-term care role. When compared to acute facilities, the St. Peter's facility lacks infrastructure such as emergency, operating rooms, diagnostic services and intensive care. The building has limited potential for uses other than for which it was designed.

The greatest potential for expansion on this site lies in the structural capacity of the east wing built in 1974 to accept 3 additional floors.

Hamilton Psychiatric Hospital

The site is 82 acres in extent, and accommodates 11 separate buildings with a total gross area of 473,508 square feet; the buildings date from 1880 to 1959. The largest building structure is 331,380 square feet, or 70% of the total and was built in 1959. Various unsatisfactory technical and regulatory conditions were noted in the assessment of this facility

Summary of DHC Facility Assessment

The Health Action Task Force of the Hamilton-Wentworth District Health Council noted the site renewal costs necessary to permit continued use of the facilities according to current building standards. Their data as reported in their report "Our Health, Our Future" were broken down into finer detail regarding costs associated with architectural, mechanical and electrical upgrading and renovations. These data were summaries of the facility assessment report for each hospital in the Hamilton Region done by Associated Planning Consultants in February, 1996. The report cautions that that these "renewal" costs should be considered "order of magnitude"

(plus or minus 10% - 20%). The cost estimates were also based on the assumption of continuing use of the building in their current roles or activity levels.

The following chart summarizes the DHC estimates:

Hospital Site	Gross Floor Area	Replacement Cost	Renovation Cost	
			Total	% of Replacement Cost
<i>McMaster</i>	833,080	\$179,112,200	\$5,418,800	3.0
<i>Chedoke</i>	573,214	\$91,714,240	\$5,508,800	6.0
<i>Henderson</i>	836,740	\$150,613,200	\$9,098,117	6.0
<i>General</i>	714,293	\$153,572,995	\$8,143,316	5.3
<i>St. Joseph's</i>	771,790	\$138,933,200	\$8,140,316	5.9
<i>St. Peter's</i>	186,130	\$25,127,550	\$3,293,100	13.1
<i>Ham. Psychiatric</i>	479,508	\$76,721,280	\$17,437,467	22.7
<i>Stoney Creek HC</i>	88,000	\$11,880,000	\$472,254	4.0

Source: The Health Action Task Force of the Hamilton-Wentworth District Health Council Report, *Our Health, Our Future*, May, 1997. Page 87

These data indicate that, on a percentage of total replacement cost, the facilities that warrant the most work just to maintain their current roles are the Hamilton Psychiatric Hospital and the St. Peter's Hospital sites.

Hospital Site	% of Replacement Cost
<i>Ham. Psychiatric</i>	22.7%
<i>St. Peter's</i>	13.1%
<i>Henderson</i>	6.0%
<i>Chedoke</i>	6.0%
<i>St. Joseph's</i>	5.9%
<i>General</i>	5.3%
<i>Stoney Creek HC</i>	4.0%
<i>McMaster</i>	3.0%

Using the DHC data, the above chart sorts the facilities in descending order according to the percentage costs associated with renovations necessary to meet current standards..

In another section of the DHC report indicating the estimate of space requirements for the option of maintaining five sites (i.e., McMaster, Chedoke, Henderson, General and St. Peter's) the new construction was estimated to be 755,007 square feet with renovation estimated to be 376,875 square feet. Of the total new construction 570,360 square feet was associated with the Chedoke site and 85,416 with the St. Peter's site. These represent respectively, 99.5% and 45.9% of current space on each site, which is much higher than the estimates of new space requirements for other sites.

DHC Redevelopment Cost Analysis		Proposed	New Construction as
Hospital Site	Gross Floor Area	New Construction	% of Total GFA
<i>McMaster</i>	833,080	0	
<i>Chedoke</i>	573,214	570,360	99.5%
<i>Henderson</i>	836,740	68,796	8.2%
<i>General</i>	714,293	30,435	4.3%
<i>St. Peter's</i>	186,130	85,416	45.9%
Total Area/Construction	3,143,457	755,007	
Total Renovation		376,975	

Overall Facility Assessment

Some facilities were not suitable for acute care siting, since they lack expensive infrastructure to accommodate operating rooms, diagnostic services and critical care systems. Based on substantial excess capacity and the conditions of both the Hamilton Psychiatric Hospital and the Chedoke site, the HSRC concluded that these two sites should not be considered in the development of options for hospital services and siting of other related hospital services.

SECTION VII: ACUTE CARE SERVICES

The HSRC's objective is to achieve efficiencies for inpatient services based on benchmarking best practices. There is opportunity to achieve efficiencies in all areas of the province, including those areas which already demonstrate low utilization rates. Low or high utilization rates, in some areas, may reflect differences in population characteristics.

Further analysis of clinical utilization identifies opportunities to improve clinical efficiency through:

- reducing/eliminating Alternate Level of Care (ALC) patient days
- reducing length of stay to meet benchmark performance
- reducing avoidable admissions.

Alternate Level of Care

Alternate level of care cases are those where the patient is ready for discharge from an acute care bed, but the required alternative level of service is not immediately available. The patient must then occupy an acute bed when his or her needs could be better met in an alternative less costly setting, such as a long-term care facility. The reporting of ALC cases is a clinical decision which the attending physician must indicate on the patient's chart.

In the Hamilton hospitals, the ALC caseload was approximately 10.1% of total days and used 123 beds in 1995/96. The HSRC has noted that the rate for the Hamilton hospitals is higher than that for other communities. This is due to several factors including the lack of long-term care beds.

Table 15: Alternate Level of Care Residents (excludes acute psychiatric, newborn and out-of-province residents) 1995/96

	HHSC Henderson site	HHSC General site	HHSC McMaster site	St. Joseph's Hospital	Total Hospitals
ALC Separations	327	280	115	240	962
ALC Separations as % Total Separations	2.4%	2.9%	0.9%	1.3%	1.8%
ALC Days	11,530	10,339	4,374	14,219	40,462
ALC Days as % of Total Days	12.85%	9.9%	5.4%	11.6%	10.1%
Calculated Acute Beds (Days/365/Wtd Occup. Rate*)	35	32	13	43	123

*Calculated from total days at 90 % occupancy

Acute Length of Stay

The 1995/96 length of stay is similar to other comparable sized communities in Ontario. Twenty percent of acute hospital days could be conserved if the top 25% performance level for similar sized hospitals were adopted. This represents a savings of 182 beds (see Table 14).

Avoidable Admissions

Avoidable admissions are measured by the number of distinct case types that can be provided on an ambulatory basis or diverted to other service providers in both the health and social services systems.

There has been a significant shift to day surgery across the province over the past few years. If the Hamilton hospitals were to achieve the same performance levels as the top 25% performance level hospitals, 11 additional acute care beds could be saved.

Data indicate a very low number of admissions that are categorized as avoidable (*Case Mix Group CMG 851 - Other Factors Causing Hospitalization*). This category includes admissions that can generally be diverted to community services or dealt with on an ambulatory basis.

A number of cases have been categorized as *May Not Require Hospitalization* (MNRH). If 25% of the MNRH days can be diverted to either hospital-based ambulatory care or to other providers outside the hospital, then further clinical efficiency is achieved.

There is also a perception that reducing bed numbers reduces services but this is simply not warranted. If inpatient hospital beds were used appropriately, that is, if the clinical efficiencies described above were met, fewer beds would be required to treat the same volume of patients. As the following graph indicates, a number of inappropriate inpatient days could be removed post-utilization improvements (centre bar). The equivalent number of beds used in Hamilton in 1995/96 at 90% weighted occupancy rate was 1,217 beds. After utilization improvements, the same volume of patients could be treated with 1,060 beds.

The projected increase in volume to the year 2003 is added to the 898 acute beds (see next table) to keep up with the expected population increases and changes in the age mix of the population. These estimates bring the bed complement (excluding newborn, psychiatric and out-of-province beds) up to 1,060 beds by year 2003. The HSRC used these numbers to estimate the number of required hospital beds, ICUs and operating rooms.

Growth in acute services (separations, days) is calculated using a method that addresses changes in the composition of the population (i.e., aging). Rates of expected caseload in 2003 compared with the province and the days associated with the increase are added to the caseload and patient days after conservable cases and days associated with clinical utilization efficiencies are removed. As noted above the final number of cases in Hamilton-Wentworth hospitals is estimated to be higher in 2003 than in 1995/96.

Implication of Utilization Improvements

If the potential conservable days associated with improvements in clinical efficiency were achieved, a total of 104,683 inpatient days or 319 acute beds could be saved in Hamilton hospitals. As summarized in table 16, these targets represent a potential reduction of 26% in acute inpatient beds from March 1996.

Table 16: 1995/96 Utilization Improvement Potential

	Total, Hamilton Hospitals		
	Patient Days	Equivalent Beds at 90% occupancy	Percent Breakdown
Total Beds Staffed and In Operation (March 31, 1996)	1,294		
Benchmark Weighted Occupancy Rate	90.6%		
Current Utilization Rate per 1,000 ESI Referral Population	754.5		
Acute Patient Days (excluding Psychiatry) 1995/96	399,695	1,217	100%
Conservable Patient Days			
Moving 100% of ALCs	40,462	123	10.1%
Moving 100% of CMG 851	184	1	0
Moving 100% of CMG 910	3	0	0
Moving 25% of MNRH	544.9	2	0
Days Surgery Potential at 75th percentile	3716.2	11	1.3%
Adjustment to 75th percentile ALOS	59,773.5	182	15%
Total Conservable Patient Days	104,683.6	319	26%
Balance Acute Patient Days	295,011		
Acute Beds Required (at benchmark weighted occupancy rate)		898	
ESI Referral Population	685,706		
Projected Utilization Rate	430		

Source: PDST, Release 4.1

Total Acute Care Bed Requirements

In March 1996, the Hamilton hospitals operated 1,294 acute care beds. When psychiatry cases and neonates are removed from the analysis, a total of 399,695 acute patient days were utilized. At a 90% occupancy rate, these 399,695 patient days translate to 1,217 beds. Analyzing the 1995/96 data, the HSRC identified the number of patient days associated with alternative level of care, as well as those identified as conservable through length of stay reduction and avoidable admissions. A total reduction of 104,683 patient days (or 319 beds at 90% occupancy) was identified. The result is that 898 acute care beds would have been required to accommodate the same caseload that received care in 1995/96.

Siting of Adult Acute Care Services

There are four hospital sites presently delivering both inpatient and outpatient adult acute care services in Hamilton and an ambulatory care site in Stoney Creek delivering ambulatory care services. In consideration of the facilities analysis and other factors, the siting options for adult acute care services would have to involve all four sites. HSRC recommends siting adult inpatient acute care services at these four sites:

- HHSC General
- HHSC McMaster
- HHSC Henderson
- HHSC St. Joseph's.

In addition the HSRC recommends the retention of the Stoney Creek site for ambulatory purposes.

The St. Peter's Hospital site was not considered for siting of adult acute care services for reasons discussed above.

As noted earlier decisions regarding preferred options represent a balance between the criteria of access, quality and affordability. The rationale for the location of acute services on four sites included consideration of the following:

Access

The sites are geographically dispersed in Hamilton with three in the downtown area and one on the mountain. The city population currently accesses all four sites for their services, and each of the sites has emergency access. Population growth to the year 2003 is expected to be highest in the northwest quadrant of the city, on the

mountain; siting acute care services on the mountain will provide continued access for this population.

Quality

Clinical Coherence

The linkages between host hospitals and regional cancer centres is examined in more depth in succeeding paragraphs. Because of these linkages there is a necessity to maintain an adjacent acute care hospital as the host facility to support for the cancer centre's activities. The HHSC Henderson site, though older than the other acute care sites, is adjacent to the recently redeveloped Regional Cancer Centre and should be maintained to support the RCC's activities in providing co-ordinated, comprehensive cancer treatment services.

In Hamilton, there is a strong relationship between the University (McMaster) and the McMaster site of the Hamilton Health Sciences Corporation. Approximately forty percent of the space at the McMaster site is used for university purposes. The synergies between the university and the hospital in basic research, academic teaching and clinical epidemiology are best served by this arrangement.

Critical Mass

There is a need to maintain the HHSC Henderson site as a host hospital to support the regional cancer centre. In locating the acute program at the Henderson site, the HSRC has attempted to maintain critical mass while reducing some acute care services at the Henderson site to enhance clinical coherence in some programs(see page 52).

Affordability

Each siting option has different implications for capital costs. The HSRC has attempted to minimize capital costs wherever possible in arriving at a siting decision. Operating cost differences do not vary as significantly.

Acute Program Rationalization

The Hamilton Health Sciences Corporation has, over the past two years, rationalized services and programs between their four sites to improve critical mass in many areas. In siting clinical activity the HSRC has attempted to reflect the changes made by the HHSC. Other program activity transfers were also assessed by the HSRC in the siting of activity to improve critical mass and enhance clinical coherence. Among the clinical services considered by the HSRC for rationalization were:

- respirology

- obstetrics
- gynaecology
- oncology

It is not the intention of the HSRC to micro-manage the clinical activity within HHSC or in the Hamilton-Wentworth hospital system. The objectives of the HSRC relating to the program transfers are two-fold: first, to reflect the changes that have already been made and, second, to assess the capital requirements and cost savings as a result of program transfers. When the hospitals perform more detailed analysis during their functional programming, the final numbers of beds and ambulatory care visits may change. The HSRC intends this to be a framework rather than a detailed blueprint. The following sections outline the program transfers and the rationale behind them.

There have been significant changes since 1995/96 in Hamilton hospitals due to the formation of the Hamilton Health Sciences Corporation. These include changes in the location and sizing of some clinical activities. The HSRC has attempted to reflect what HHSC has already accomplished but there could be some variations as a result of updated information.

The HSRC approach in consolidating programs is to build on the current strong clinical service profile and extensive supporting infrastructure of each site. This will improve the quality and accessibility of services to meet patient needs and help achieve the HSRC's utilization benchmark levels. Consolidation of services will also optimize use of surplus capacity.

Table 17 provides a summary of the adult acute program transfers in the recommended option for the Hamilton hospitals.

Table 17: Summary of Adult Acute Program Transfers in Hamilton Hospitals

Transfer From	Transfer To	Program
Henderson	St. Joseph's	50% Pulmonary
Henderson	McMaster	OBS, Gyn, and Neonatology
McMaster	Henderson	Oncology

Oncology

The HHSC Henderson site, largely because of its role as the host hospital for the Regional Cancer Clinic, is a major provider of oncology services. The HHSC Henderson site is located in the mountain area, one of the fastest growing areas in Hamilton. Due to the poor physical condition of the HHSC Henderson site, the HSRC sought to create a smaller full-service acute hospital with a focus on oncology and related services.

In the spring of 1997 Ontario launched Cancer Care Ontario, a new agency to oversee cancer care in the province. Cancer Care Ontario (CCO) is the province's principal advisor on cancer issues, and is responsible for long-term planning of all aspects of the cancer care system. The organization will set direction and provide leadership for a broad range of services such as treatment, prevention, research and support services. Cancer Care Ontario will also establish standards for care and monitor their use to ensure that patients across the province receive the same high quality of care.

The cancer care system is complex and often difficult for patients and providers to navigate. Patients may not be aware of all the treatment options and support services available to them; a co-ordinated system for cancer care professionals, institutions and agencies is lacking. CCO is a response to this gap: CCO will link community surgeons and the institutional cancer care system, and will facilitate consultation with other cancer specialists and surgeons.

The cost of cancer care is rising in this era of restricted health care funding. Each year, the number of new cases of cancer grows between three and four percent, in part because of the aging population. At the same time, many effective but expensive new drugs are entering the market, often costing thousands of dollars per patient. CCO will facilitate health care professionals tracking more effectively which treatments are the best, and which services are the most useful to patients. Using this information, CCO will be able to meet future needs by streamlining the delivery of cancer services, eliminating duplication, and ensuring that money is spent wisely on the most important priorities.

CCO will do most of its co-ordination work through regional divisions of the organization called Cancer Care Ontario--Regional (CCOR), located across the province. The regional organizations will bring together all those who provide services to cancer patients, from family doctors and hospitals to home care agencies. These regional networks will identify local needs, establish priorities, and determine priority activities to improve or enhance cancer services in the region (e.g., providing additional training to community physicians in small towns; eliminating the need for patients to travel to receive chemotherapy; producing a resource manual for patients on available support services and self-help groups).

Each CCOR network will be accountable to the provincial office of Cancer Care Ontario, and to its communities through an annual public report on the state of cancer services in the region.

The Ontario Cancer Treatment and Research Foundation operates several Regional Cancer Clinics (RCCs) associated with hospitals. RCCs offer a variety of ambulatory cancer treatment services in radiation and medical oncology. While similar freestanding facilities exist in other jurisdictions, the relationship between the RCC

and its host hospital is viewed as fundamental to the efficient and effective functioning of the RCC by the Ontario Cancer Treatment and Research Foundation. Host hospitals offer a variety of services to complement the activities of the RCC:

- diagnostic services such as medical imaging and laboratories
- clinical support services such as haematology
- beds for patients whose conditions warrant inpatient stays
- administrative and support services such as finance, materials management, medical records, etc.

In some instances RCCs have shared staff positions with their host hospitals, thereby reducing overhead costs to both organizations. The physical separation of a RCC and a host hospital could potentially reduce the efficiency and effectiveness of both organizations and unnecessarily fragment care services for cancer patients.

In Hamilton, the Henderson site of the HHSC has served as the host hospital for the central west RCC for several years. The expansion and redevelopment of the RCC facilities in the early nineties was premised on the continuation of this relationship.

Transferring oncology program from McMaster to Henderson will affect both critical mass and clinical coherence of these services. A higher number of oncology cases in Henderson will increase critical mass and will concentrate specialized skills and expertise. It will also improve clinical coherence of these services by consolidating most cancer and related services on this site. In sum, as represented in table 18, the number of oncology beds at the Henderson site after the transfer and adjusted for growth to the year 2003 would be 76 beds, up from 44 beds in 1995/96.

Table 18: Oncology

Program	Pre-Transfer (1995/96)		Post-Transfer (2003)	
	Henderson	McMaster	Henderson	McMaster
Oncology	44 beds	20 beds	76 beds	0

Cardiac Services

The planning of specialized cardiac services must be undertaken within a broad context guided by provincial targets and standards. The Cardiac Care Network of Ontario (CCN) is an advisory body to the Minister of Health mandated to advise on a province-wide cardiac care system, monitor waiting patterns for surgery services and develop guidelines and standards for access and delivery of services.

The CCN has established adult population (age 20+ years) planning benchmarks as follows:

- coronary arterial bypass grafts (CABGs) of 100 bypass surgeries per 100,000 age and sex adjusted population
- 357 diagnostic catheterizations/100,000 population
- 100 percutaneous transluminal coronary angioplasties⁵ (PTCA) or angioplasty/100,000 population, and
- 55 stents⁶/100,000 population.

In its September 1997 report the Consensus Panel on Cardiac Catheterization Laboratory Services in Ontario identified that there is insufficient capacity in the central west region for the projected cardiac catheterizations required by 1998/99. No specific study has been completed on the available capacity in current centres to meet the needs for cardiac surgery in future years. The panel recommended that catheterizations services be planned in tandem with additional tertiary cardiac centres and provide diagnostic and interventional procedures including cardiac surgery.

Specialized cardiac services include diagnostic catheterizations (angiography), invasive catheterizations (angioplasty or percutaneous transluminal coronary angioplasty--PTCA), stenting, and cardiac surgery (including bypass grafting and valve surgery). There are currently eight full-service cardiac centres in the province located in Metropolitan Toronto (3), Hamilton, Ottawa, London, Kingston and Sudbury. There are an additional four centres with services limited to diagnostic cardiac catheterizations located in Toronto, Windsor, Thunder Bay and Sault Ste. Marie.

There are several options for providing the increased volume of services in the Central East and West regions:

1. Expand capacity at existing sites.
2. Establish a new site for both diagnostic and interventional services including surgery.
3. Add cardiac surgery services to the Centenary Health Centre which already provides diagnostic catheterizations and is located in the region in which expansion is warranted.

Each of these options requires full evaluation with respect to current capabilities and capacity for expansion, critical mass and quality indicators, human resource capacity and implications, and impact on existing regional centres.

⁵ PTCA or angioplasty is a technique in the treatment of atherosclerotic coronary heart disease and angina pectoris.

⁶ Stents are a tubular scaffold used in conjunction with PTCA. The provincial stent rate is higher than the previously set 55/100,000 population. Work is currently under way to revise this rate.

As indicated in the *Essex County Health Services Restructuring Report* of October 1997, the HSRC will convene an expert panel to advise on critical mass for specialized cardiac services; criteria for siting additional (if required) cardiac centres; and the siting of cardiovascular surgical services in Ontario based on population need and projected growth.

Terms of Reference

The scope of the expert panel's work will be guided by the following draft terms of reference:

- Determine available surgical capacity at existing centres.
- Review literature and international experience to identify and determine guidelines for the optimal mass of cardiovascular surgeries.
- Make recommendations on siting (if required) based on population projections and surgery volume targets including the impact on and relationships with existing centres
- Make recommendations regarding optimal volumes for cardiac surgery and catheterizations, considering quality indicators, manpower and cost/benefit factors.

In reviewing opportunities for provincial guidelines and siting, the expert panel will take into consideration issues related to:

- optimal mass for quality of care
- anticipated volumes and capacity to 2003
- access:
 - of the patient and family to pre-admission care, in-hospital services and specialty ambulatory follow-up clinics
 - to cardiac services once designated for surgery.
- affordability

Membership

The expert panel will be led by a chair appointed by the Health Services Restructuring Commission and will include representatives from the Ministry of Health, Cardiac Care Network of Ontario and the Institute for Clinical Evaluative Sciences (ICES).

Maternal and Newborn Care

The HSRC believes that a high-quality, accessible maternal-child system is built on a strong foundation of primary and secondary care services that meet the needs of most women and children through low-risk birthing services, ambulatory and outreach

services. Accordingly, the HSRC recommends that the specialized maternal and newborn services be concentrated in fewer sites in order to maximize the critical mass and improve quality standards.

The HSRC, during its review of maternal and newborn services in central west, was guided by the Metro Toronto Child Health Network's recommended *Guidelines for Clinical Scope of Perinatal (Maternal/Newborn) and Paediatric (Child/Adolescent) Services* (see Appendix D). These guidelines were developed by the Metro Toronto Child Health Network as part of the mandate established by the HSRC's directions in the Metro Toronto Report (July 23, 1997). While the guidelines were developed by representatives of Metro hospitals for application in Metro Toronto, the HSRC believes that all or part of the guidelines may have application to Hamilton and beyond. The HSRC is currently reviewing the guidelines and welcomes feedback on the clinical services descriptions they contain.

The HSRC, believing that a regional system of maternal and newborn care is desirable, recognizes that all hospitals have a clear role in the regional system; Level I community hospitals provide low-risk birthing services, newborn care and some paediatric services; and Level II hospitals provide moderate-risk obstetrical services, newborn care and paediatric services; Level III hospitals provide highly specialized maternal care for high-risk obstetric patients, full newborn care and paediatric services.

In 1995/96, maternal and newborn services were provided at three sites in Hamilton: St. Joseph's Hospital and HHSC (McMaster and Henderson sites). Each had 55% and 45% of obstetrical caseload⁷ respectively. The number of births by hospital site in 1995/96 is summarized as follows:

Table 19: Births in Hamilton Hospitals

Hospital/Site	Births (1995/96)	% of Total Births (1995/96)
Henderson	1,477	23%
McMaster	1,457	22%
St. Joseph's	3,590	55%
Total	7,160	100%

Source: CIHI 1995/96

According to the materials received from the HHSC, maternal and newborn services from the HHSC Henderson site were transferred to the HHSC McMaster site in September 1997. The HSRC supports this consolidation of services at McMaster and believes the quality of services will be enhanced by increasing the critical mass, the number of deliveries, while clinical coherence will be enhanced by consolidating

⁷ Patient Service Newborn, CIHI 1995/96

maternal and newborn care at the McMaster site, the regional centre for paediatric services. However, removing maternal, newborn and gynaecology services from Henderson would reduce the availability of full services at this site. The HSRC supports the continued provision of obstetrical services at the St. Joseph's Hospital

Represented in the table 20 are the number of obstetrical beds at the Henderson and McMaster sites in 1995/96 and after the program transfer, adjusted for utilization improvements and growth to the year 2003.

Table 20: Maternal and Newborn Services

Program	Pre-Transfer		Post-Transfer	
	Henderson	McMaster	Henderson	McMaster
OBS	14 beds	27 beds	0	41 beds
Gynaecology	13 beds	4 beds	0	19 beds
Neonatology	3 bassinets	10 bassinets	0	13 bassinets

Respirology Services

St. Joseph's Hospital has a substantive respirology and thoracic surgery program which consists of three components:

- the Firestone Regional Chest and Allergy Unit, a large ambulatory program that receives 18,000 visits annually
- the chest unit, which provides a full range of severe acute and chronic respiratory disease management services
- the regional thoracic surgery program, where most of the hospital's adult surgeries are performed.

The academic productivity of this program has been evaluated by the International Scientific Institute and was rated as one of the best in the world in terms of scientific output.

In HSRC's review of patient activity in the pulmonary program cluster for 1995/96, it was noted that 35% of all separations, which accounted for 38% of all weighted cases, occurred at St. Joseph's Hospital.

Respirology is a basic service required in all full-service hospitals with emergency departments. Paediatric respirology service will be required at the McMaster site; the General site will need the expertise of this specialty for its tertiary care programs and the Henderson site will need respirology to support for cancer patients.

It is the HSRC's view that there should be consolidation of respirology programs to further enhance patient care. Therefore, the HSRC recommends that St. Joseph's

Hospital be formally designated as the lead hospital for the regional respirology program. Taking into consideration the need for this service at all four sites to complement programs at these sites, the HSRC is recommending the two hospitals and McMaster University develop an appropriate plan to achieve this objective.

Table 21 contains the details regarding the inpatient beds dedicated to respirology in 1995/96 and after the transfer between the HHSC Henderson and St. Joseph's Hospital. Because the HSRC methodology for program clusters identifies pulmonary services as a program the HSRC has used this designation in its analysis. It is assumed that the respirology services are in the pulmonary program cluster. In sum, the pulmonary beds at St. Joseph's increase from 21 to 32, taking into account utilization improvements and growth to the year 2003. There is a corresponding drop of five beds at the Henderson site of the HHSC.

Table 21: Pulmonary Services

Program	Pre-Transfer (1995/96)		Post-Transfer (2003)	
	St. Joseph's	Henderson	St. Joseph's	Henderson
Pulmonary	21 beds	11 beds	32 beds	6 beds

Ambulatory Services

As noted earlier each site will experience an increase in ambulatory activity between now and the year 2003. The HSRC has accounted for the increases in activity in developing the capital estimates related to the implementation of the restructuring option. The increases in ambulatory visits were estimated based on the clinical profile of each site.

The St. Joseph's Hospital operates a free-standing ambulatory facility at a Stoney Creek location; the St. Joseph's Health Care Center. This facility has been unique in Ontario experience in regard the size and scope of the ambulatory activity. The HSRC's preferred restructuring option maintains this facility and its activities in their current form. The HSRC assumed that there is capacity for additional growth in activity in the current building envelope.

Siting of Children's Acute Care Services

There are a number of significant issues regarding paediatric services and neonatal intensive care services in Hamilton-Wentworth. The four acute inpatient and outpatient sites were considered once again in siting options. Each siting decision was based on an assessment of the options against the criteria of access, quality and affordability.

Paediatric Services in Hamilton-Wentworth Hospitals

Child and adolescent services provided by a number of facilities, programs and agencies may create unnecessary duplication and inefficient use of resources. Such fragmentation may indeed contribute to poorer outcomes of care. Furthermore, scarce resources may be eroded from children's services in a variety of settings without proper assessment of their impacts. To address both service fragmentation and the potential erosion of resources, the HSRC focused on the delivery of children's services building upon work done in Hamilton-Wentworth in the past.

In a report entitled *Rationalization of Seven Hospital Based Programs and Services in Hamilton Wentworth* November 1995, the Joint Action Task Force developed two final options for the location of paediatric services. The options were: consolidation of all inpatient medical and surgical services, outpatient and day surgery at the McMaster site; and consolidation of all tertiary services at McMaster site with secondary services at both McMaster and St. Joseph's Hospital. The HSRC endorses the option to consolidate the paediatrics program and recommends locating it at the McMaster site, the current designated paediatric hospital for the central west region.

Most paediatric services in 1995/96 were provided at both Hamilton hospitals, the HHSC and St. Joseph's Hospital, though the paediatric caseload at St. Joseph's Hospital had been falling over the past few years. In sum there were 5,813 cases and 30,713 days (excluding obstetrics) associated with patients under 18 years of age. Weighted cases amounted to 7,757, which suggests an intensity of services comparable to that in referral centres for paediatric care in both London (5,536 weighted cases) and Ottawa (8,302 weighted cases). Surgical paediatric cases (excluding obstetrics) amount to 1,710 separations and 10,300 patient days, and the number of paediatric surgical weighted cases (2,944) indicates that the intensity of these services is not unlike that in other paediatric referral centres.

Table 22: Paediatric Workload of Hamilton Hospitals

Hospital	Patient Days	Separations	Weighted Cases
MUMC	19,208	3,535	5,235.5
Hamilton General	828	137	242.1
Hamilton Henderson	1,633	194	297.5
St. Joseph's	9,044	1,947	1,982.4
TOTAL	30,713	5,813	7,757.5

Source: CIHI Inpatient Abstract 1995/96 (excluding obstetrical cases)

The majority of paediatric services were provided by the HHSC (67%). In terms of the location of the paediatric cases, 67% were located at the Hamilton Health Science Centre (59% at MUMC, 4% each at both the General and Henderson sites), while

33% were treated at St. Joseph's Hospital. The majority of paediatric surgical cases (73%) were treated at the HHSC.

Accessibility

Access to acute inpatient services for paediatric patients is not compromised by locating the program at either the McMaster site or at St. Joseph's Hospital. They are relatively close to each other and either location is within reasonable driving distance for all Hamilton and regional residents.

Access to emergent paediatric care, however, may be affected as a result of the consolidation of services at the MUMC site. Of St. Joseph's total paediatric admissions, 48% enter through the emergency room. Of these cases, pulmonary-related disorders account for approximately 25% of total volume. It has been the experience in other communities that residents seek emergent care at the hospital closest to them. Therefore, the HSRC will give notice of its intention to direct St. Joseph's Hospital to provide a paediatric observation unit within its emergency department to accommodate paediatric emergency cases.

Table 23: Paediatric Admissions through the Emergency Room of Hamilton Hospitals

Hospital	Patient Days	Separations	Weighted Cases
MUMC	7,565	1,692	1,860.4
Hamilton General	573	88	172.0
Hamilton Henderson	191	65	50.2
St. Joseph's	3,160	943	773.5
TOTAL	11,489	2,788	2,856.1

Source: CIHI Inpatient Abstract 1995/96 (excluding obstetrical cases)

Quality

Critical Mass

The issue of critical mass is significant in all siting decisions, and no less so in the paediatric program: the number of cases must be sufficient to sustain medical, nursing and support departments (e.g. clinical laboratory and diagnostic imaging) and to allow the operation of a full clinical service 24 hours a day, seven days a week for inpatient services. Therefore the caseload must support sufficient numbers of medical staff to allow for effective coverage during evenings and weekends.

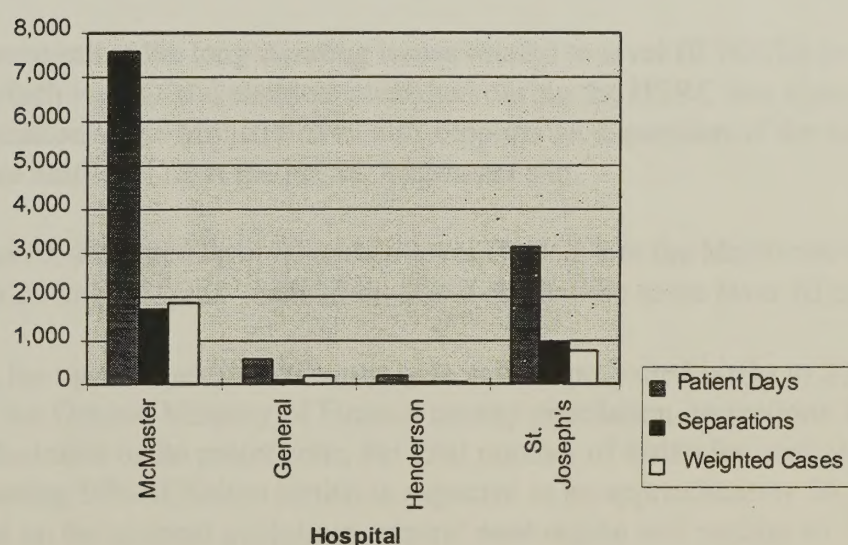
In the case of Hamilton, there are 82 paediatric beds, located at the McMaster site of the HHSC and St. Joseph's Hospital. Hamilton and the central west region would be best served by the creation of one large consolidated paediatric program at a single regional site, resembling those in Ottawa and London. Consolidating the expertise and resource base to one site would enhance children's acute care services in central west Ontario.

Clinical Coherence

Clinical coherence refers to the mix of clinical activities that fit together to address, as fully as possible, a complete episode of care. Programs develop synergy as a result of co-location, and this enhances the quality of care.

Currently, the McMaster site of the Hamilton Health Science Centre accounts for approximately 60% of patient days and paediatric separations. If one examines weighted cases, the McMaster site provides approximately 65% of the paediatric weighted cases, which suggests a higher acuity for the volume provided. The McMaster site is a full service paediatric hospital and the referral centre for the central west region.

Paediatric Workload of Hamilton Hospitals



There is little doubt that siting the paediatric program at the McMaster site will generate a corresponding requirement to ensure the availability of sufficient paediatric resources at St. Joseph's Hospital, in order to guarantee an acceptable quality of paediatric emergency care.

These resources may include:

- a paediatric observation unit in the emergency department at St. Joseph's in keeping with modern practices of paediatric medicine
- remote telemetry and telemedicine technology to minimize physician and patient inconvenience and reduce transfers of cases between sites.

The balance of considerations supports the consolidation of paediatric services at the HHSC's McMaster site. By 2003, accounting for utilization improvements and growth, the number of paediatric beds at the HHSC McMaster site will increase to 82 beds from 54 beds in 1995/96. The corresponding number at St. Joseph's Hospital will fall to 0 from the 28 beds in 1995/96.



Table 24: Paediatric Services

Program	Pre-Transfer		Post-Transfer	
	St. Joseph's	McMaster	St. Joseph's	McMaster
Paediatric	28 beds	54 beds	0	82 beds

Neonatal Intensive Care Services

High risk obstetrics and neonatology are specialized tertiary services that are required for approximately 3% of all births. These services are currently located in regional sites including Toronto, Hamilton, London, Ottawa and Kingston, with modified units in Windsor, Sudbury, North Bay, Thunder Bay and Sault Ste. Marie. They are part of a regional system of care for mothers and infants. National guidelines⁸ recommend 3 beds for level II and 1.75 beds for level III NICUs, per 1,000 births.

The HSRC recognizes the long standing issues related to level III NICUs in Hamilton, which various stakeholders identified during the HSRC site visits. The HHSC submission to the Ministry of Health supports an expansion of the neonatal intensive care unit level III at the HHSC McMaster site.

Hamilton has 33 dedicated level III and 14 level II NICUs at the McMaster site. St. Joseph's has 20 level II "plus", indicating that it can handle some level III caseload.

In assessing the need for additional capacity to service projected births to 2003, the HSRC used the Ontario Ministry of Finance county population projections 1992-2021. As illustrated in the projections, the total number of births for central west region (including 50% of Halton births) is expected to be approximately 26,728 in 2003. Based on the national guidelines, central west region will require 47 level III beds and Hamilton-Wentworth will need 20 level II NICU beds in 2003. Table 25 represents the breakdown of the level III bassinets by county in central west region.

⁸ Family-Centred Maternal and Newborn Care: National Guidelines

Table 25: Birth Projections and NICU Requirements for Central West

County	Projected 1995	Projected 2003	Level II NICU	Level III NICU
Hamilton-Wentworth	6,876	6,501	19.5	11.4
Dufferin	708	750	2.2	1.3
Wellington	2,515	2,431	7.3	4.2
Niagara	5,260	5,182	15.5	9
Waterloo	6,349	6,148	18.4	10.8
Haldimand-Norfolk	1,293	1,348	4	2.3
Halton*	2,327	2,763	8.3	4.8
Brant	1,636	1,605	4.8	2.8
Total	26,964	26,728	80	47

Source: CIHI 1995/96 and Ministry of Finance, population projections 1992-2021

**50% of Halton births*

Even though the guidelines suggest 20 level II beds are required for Hamilton, the HSRC concludes that both St. Joseph's and the McMaster site of HHSC will maintain their current 34 level II NICU which will require no capital investment.

In addition, the HSRC recommends that the number of level III NICU beds be increased to 47 from 33 at the McMaster site to service the central west region. This is an increase of 14 level III NICU beds for the region.

Table 26: 1995/96 Neonatal Intensive Care Beds

Level of NICU Bed	St. Joseph's Hospital	HHSC McMaster Site
Level II	20	14
Level III	n/a	33

Table 27: HSRC Forecast 2003 Neonatal Intensive Care Beds

Level of NICU Bed	St. Joseph's Hospital	HHSC McMaster Site
Level II	20	14
Level III	n/a	47

Increasing the level III NICU beds at the HHSC McMaster site has significant capital cost implications which are summarized in the capital cost estimates for the site.

Summary of Adult and Children's Acute Care Program Transfers

The impact of the acute program transfer on the number of inpatient beds in the HSRC's recommended reconfigured hospital system in Hamilton is summarized as follows:

Table 28: Summary of the Acute Bed Configuration in the Reconfigured System in Hamilton

Program	St. Joseph's Beds, 2003	Henderson Beds, 2003	General Beds, 2003	McMaster Beds, 2003
Estimated acute beds for 2003 (pre-transfer)	315	201	321	223
Paediatric	-28			+28
Pulmonary	+7	-7		
Oncology		+24		-24
Obstetrics		-15		+15
Gynaecology		-14		+14
Neonatology		-3		+3
Total (post-transfer)	294	186	321	259

These figures do not include the increase in level III neonatal intensive care beds.

The related impact on emergency and ambulatory services is estimated in the final site configurations. These services relate directly to the inpatient acute beds, including psychiatric. As the beds are transferred between sites and adjusted for growth, the emergency services and ambulatory care is adjusted as well.

SECTION VIII: NON-ACUTE CARE SERVICES

Complex Continuing Care

Sizing Methodology for Complex Continuing Care

The term, “complex continuing care” as used in other studies and as accepted by the HSRC connotes the care received by a patient who requires hospitalization for a chronic condition. The essential difference between the current designated “chronic” beds and those deemed to be “complex continuing care” relates to the nature of the patients served and the services provided. In current “chronic” care facilities and programs there are a number of patients receiving a lower level of care than could be provided in other settings, particularly in long-term care facilities. In the HSRC’s *Interim Planning Guidelines Discussion Paper* of July 1997, “complex continuing care”, much more restrictively defined than the broader “chronic” classification, was used to denote these patients’ higher degree of acuity.

The number of chronic care beds staffed and in operation in Hamilton-Wentworth in 1995/96 was 485. Chronic beds are situated at St. Joseph’s Hospital and the Henderson, McMaster and Chedoke sites of the Hamilton Health Sciences Corporation and at St. Peter’s Hospital.

Bed/Service Category	St. Joseph’s	Henderson	General	McMaster	Chedoke	St. Peter’s
Complex Continuing Care	30	38	0	35	98	284

As a result of its research, the HSRC has revised the planning target for sizing complex continuing care beds. This complement includes beds for people who require respite care in a complex continuing care environment as well as for those needing admission for palliative care that requires the support of a complex continuing care program. Based on a planning guideline of 7 beds/1,000 population 75 years of age and older, the number of complex continuing care beds required in hospital settings will be 269 by 2003. This represents a decrease of 216 beds from the 1995/96 complement of 485 chronic care beds.

Type of Care	1995/96	2003
Chronic Care	485	n/a
Complex Continuing Care	n/a	269

The HSRC believes that the reduction in complex continuing care beds must be viewed in the context of sizing the rest of the long-term care system. Reductions in these beds must be balanced by appropriate increases in the levels of service in other areas of the long-term care system (i.e., institution-based settings such as nursing homes and homes for the aged, and community-based settings such as supportive housing, long-term home care, attendant care and adult day care). The HSRC supports the gradual reduction of complex continuing care services over the next three to five years to allow sufficient time for appropriate alternative services to be put in place.

Siting of Complex Continuing Care Services

There is additional capacity remaining at the four acute care sites after consideration of siting of acute care services. There also remains a viable stand-alone continuing care facility with St. Peter's Hospital. Several options exist for the siting of complex continuing care services:

- in a stand-alone facility
- integrated in all acute care sites
- integrated in a few acute care sites.

The HSRC reviewed all three options using its assessment criteria of quality, access and affordability and concluded integrating complex continuing care services in acute care sites is the preferred option for reasons noted below.

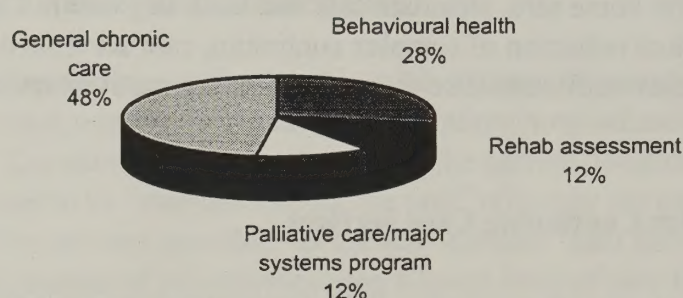
Quality

Clinical Coherence

The HSRC paper *Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies*, of July 1997 describes complex continuing care as comprised of high acuity long-term care services that can only be provided in a hospital setting. Complex continuing care patients require substantial medical intervention, access to hospital-based supports, technical resources and multidisciplinary expertise. These conditions already exist in acute care facilities. In order to improve the clinical coherence of services, complex continuing care should be co-located with acute hospital services, if there is sufficient capacity in the general hospital setting.

Currently there are two major providers of chronic care services in Hamilton: St. Peter's Hospital and the Chedoke site of the HHSC. Chronic care beds are also located at St. Joseph's Hospital and at the Henderson and McMaster sites. St. Peter's Hospital currently provides the majority of chronic services in Hamilton. The breakdown of their beds by program is illustrated in the following chart.

Chronic Care Beds Breakdown by Program in St. Peter's Hospital



Source: St. Peter's Hospital, 1997/98 operating plan; all beds are designated chronic beds.

As noted in Section VI the HSRC eliminated the Chedoke site from further considerations in locating hospital services on that site. The Chedoke site of the HHSC currently provides not only inpatient chronic and rehabilitation services but also a range of ambulatory care services that are funded by different sources. The urgent care centre, geriatric assessment and rehab, specialized rehab and acquired brain injury program are some of the outpatient services funded by the MOH. The Child and Family Centre is funded by the Ministry of Community and Social Services. The substance abuse and the pain program are marketed services not funded by the government. Other outpatient services provided at the Chedoke include: the Centre for the Study of Children at Risk, and the Educational Centre for Aging and Health. The HSRC recommends the future use of the Chedoke site for non-hospital services such as those noted above be left to the HHSC to determine.

Critical Mass

Based on a need for 269 complex continuing care beds for Hamilton-Wentworth by 2003 there is sufficient critical mass to maintain or enhance significant programs in this area. Locating complex continuing care at all four acute care sites may diminish the critical mass requirements to maximize effectiveness of services and to facilitate the academic training of physicians and other health professionals. A stand-alone site for all complex continuing care would maximize critical mass. However, it will significantly diminish clinical coherence and affect patient care access. On balance, the location of complex continuing care at a few acute care sites would enhance the overall quality of this program. For these reasons, the HSRC recommends that complex continuing care be located at three of the acute care sites. Maintaining the current complex continuing care beds at the HHSC McMaster site and enhancing this program at HHSC Henderson and at St. Joseph's would be most feasible.

Access

Complex continuing care patients access services usually on the basis of a transfer from an acute facility following an acute episode of care. Some patients are directly admitted from the community but this is thought to be the minority of cases. Since complex continuing care is a referral-based service, its location relative to populations is not a significant consideration, although patients should not be removed from their communities and linkages with family and community should be maintained wherever possible. Co-location of complex continuing care with acute care services would reduce inter-hospital transfers and enhance accessibility.

Affordability

The location of all complex continuing care services at a separate stand-alone facility would engender both operating and capital renovation costs regardless of the site. Additional capacity exists at both the HHSC-Henderson and the St. Joseph's sites after locating acute care services at both. The co-location of complex continuing care at those sites and the maintenance of 35 complex continuing care beds at the HHSC McMaster site would maximize the utilization of excess capacity and potentially reduce both capital and operating costs for individual sites.

On balance, the assessment of the criteria for siting of complex continuing care favor locating these services at the St. Joseph's and the HHSC-Henderson sites.

As a principal issue for implementation the HSRC believes that programs should be moved intact to maintain the integrity of the services and of the clinical team providing them and to minimize disruption to patients and their families.

The HSRC concludes that the complex continuing care services currently provided at Chedoke should be transferred to the Henderson site. St. Peter's should close as a continuing care facility and its programs moved to St. Joseph's Hospital and to the Henderson site of the HHSC. *The HSRC will give notice of its intention to direct St. Joseph's Hospital, HHSC and St. Peter's Hospital to work together to transfer the programs.* The plan should include the transfer of the programs provided at Easy Street. For the purpose of the capital investment the total complement of complex continuing care beds at each site has been identified as follows:

Table 29: Siting of Complex Continuing Care Beds in Hamilton Hospitals

Hospital/Site	1995-96	Complex Continuing Care, 2003
St. Joseph's	30	117
Henderson	38	117
General	0	0
McMaster	35	35
Chedoke	98	0
St. Peter's	284	0
Total	485	269

While there is a reduction in complex continuing beds, Hamilton-Wentworth is substantially under-serviced in terms of long-term care beds and places, both currently and as forecasted to 2003. The HSRC suggests that both St. Peter's Hospital and the HHSC-Chedoke site apply to the MOH for licenses to provide residential long-term care services and that these sites be converted to that use. In the case of Chedoke, only the appropriate components of the site should be converted to that use; the balance of the site will be at the apportioned discretion of the HHSC.

Rehabilitation Services

Sizing Methodology for Hospital Based Rehabilitation Services

In its discussion paper, *Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies*, the HSRC developed a series of population-based ratios for the sizing of rehabilitation services. The HSRC has adopted the use of the terms "short-term local", "long-term local" and "regional" rehabilitation to categorize levels of rehabilitation services. A planning guideline of 20 beds per 100,000 population is used to determine the sizing of hospital-based rehabilitation services (16 beds per 100,000 population using 95% occupancy for short-term and long-term rehabilitation services and transition to independent living; and four beds per 100,000 population using 90% occupancy for regional rehabilitation services).

In sizing the inpatient rehabilitation bed supply for short- and long-term local rehabilitation services the population for Hamilton-Wentworth as projected to 2003 is used. A broader population base is required for planning regional rehabilitation programs because of the relatively few patients and the highly specialized nature of both the treatment and the skills of the rehabilitation professionals. Hamilton-Wentworth will provide the regional rehabilitation for much of the central west planning region, including Brant, Halton, Haldimand-Norfolk, Niagara, half of Wellington, and Hamilton-Wentworth region.

Table 30: Summary of Regional and Local Rehabilitation Beds Required for Hamilton-Wentworth

Type of Rehabilitation Bed	Rehabilitation Planning Ratio	Planning Region	Number of Beds Required
Regional: <i>acquired brain injury; amputee; specialized respiratory; paediatric; spinal cord and trauma</i>	4 beds per 100,000 population	Hamilton-Wentworth, Brant, Haldimand-Norfolk, Niagara, 50% of Wellington, and Burlington	62 beds
Local Long-Term <i>(requiring more than 10 days of inpatient care)</i> and Short-Term <i>(requiring less than 10 days of inpatient care)</i>	15 beds per 100,000 population	Hamilton-Wentworth	84 local short and long-term
Transition to Independent Living	1 bed per 100,000 population	Hamilton-Wentworth, Brant	7 places (long-term)*
Total			146 rehabilitation beds and 7 places

*1 place is for Brant

The HSRC methodology for sizing local short and long-term rehabilitation would provide 84 beds to the year 2003. In addition seven transition to independent living places would be required in the Hamilton-Wentworth region.

Local Short-Term and Long-Term Rehabilitation

Access

Local population access to short-term and long-term rehabilitation is fundamental in planning. For regional rehabilitation services, a broader population base is considered due to the specialized nature of the services and low incidence of need in the population. Both local rehabilitation and regional rehabilitation services are referral based (i.e., over 80% of cases are referred/transferred from acute care).

Quality

Clinical Coherence

The HSRC's objective for short-term rehabilitation is to support early rehabilitation intervention following an acute care episode and to reduce the transfer of patients from acute to rehabilitation hospitals for short-term rehabilitation. The HSRC concludes that short-term and long-term rehabilitation beds should be distributed

throughout the acute care facilities in Hamilton-Wentworth in more or less equal sized units.

Critical Mass

To ensure adequate critical mass to provide for a quality program, the HSRC is recommending that the one transition to independent living bed that would be required for Brant County, be located with the beds provided in Hamilton-Wentworth.

The HSRC's objective for regional rehabilitation is to ensure that there is sufficient critical mass to provide high quality care, to maximize the efficiency and effectiveness of specialized care delivery, and to support specialized skills and expertise. The HSRC concludes that regional services should be consolidated in designated regional facilities. Hamilton-Wentworth will require 62 regional rehabilitation beds.

The regional rehabilitation beds currently located at the Chedoke site will be relocated to the General site alongside the acute programs offered in that facility, including trauma, neurosciences, neurosurgery, orthopaedics, cardiology and cardiac surgery.

Table 31 summarizes the location of the rehabilitation beds, by the type of bed, in the four acute care hospitals.

Table 31: Proposed Siting of Rehabilitation Beds by 2003

Rehabilitation Site	Regional Beds	Local Short-Term and Long-Term Beds	Total
St. Joseph's	0	25	25
Henderson site	0	20	20
McMaster site	0	20	20
General site	62	19	81
Transition to independent living		7	7
Total	62	91	153

In total, 153 rehabilitation beds are required in Hamilton-Wentworth by 2003 to account for both local and regional programs. The rehabilitation services at Chedoke will be moved to the General site, which will be the regional rehabilitation centre for central west. The above table summarizes the distribution of these beds.

Mental Health Services

Sizing Methodology for Hospital-Based Mental Health Services

The HSRC will base its planning for hospital-based mental health services across the province as follows:

- 37 beds per 100,000 adult population by the year 2000. The guideline includes 21 beds per 100,000 adult population for acute mental health and 16 beds per 100,000 adult population for longer-term mental health
- 35 beds per 100,000 adult population by the year 2003. The guideline includes 21 beds per 100,000 adult population for acute mental health and 14 beds per 100,000 adult population for longer-term mental health.

The projected adult population of Hamilton-Wentworth 2003 was used for determining the bed requirements for adult acute care beds in Hamilton. For determining the capacity of longer-term mental health beds, the projected populations of Hamilton-Wentworth, Brant County and Halton are included in the planning region. Table 32 summarizes the results of the application of the planning guidelines for both acute and longer-term mental health according to the above guidelines.

Table 32: Summary of Adult Acute and Longer-Term Mental Health Beds for 2000 and 2003 in Hamilton-Wentworth

	1995/96 (actual)	Estimated to 2000	Estimated to 2003
Acute Mental Health	82	86	91
Longer-Term Mental Health*	193	156	124
Total	275	242	215

**includes residents of Brant, Halton, and Hamilton-Wentworth regions/counties*

As the above table shows, the number of acute mental health beds will not significantly change for the residents of Hamilton-Wentworth. The HSRC will determine the location of beds which are to be allocated for Wellington, Dufferin, Waterloo and Niagara counties when it studies services in those communities.

The Hamilton Psychiatric Hospital currently provides longer-term mental health services including programs for mood disorders, dual diagnosis, acquired brain injury, geriatric psychiatry, schizophrenia and forensics.

Access

The patient origin of separations from the Hamilton Psychiatric Hospital in 1994/95 is summarized in table 33.

Table 33: Patient Origin 1994-95

Patient Origin	Hamilton Psychiatric Hospital
Brant	4%
Haldimand-Norfolk	3%
Halton	5%
Niagara	14%
Hamilton-Wentworth	62%
Other	11%

Source: Ministry of Health, 1994/95

Acute services entail local access, usually through emergency or direct referral to the hospital. Longer-term mental health services, such as those offered by the Hamilton Psychiatric Hospital, are referral-based; that is, a few facilities regionally situated accept referrals from mental health professionals and other acute hospitals. Most separations from the Hamilton Psychiatric Hospital come from within the central west planning region, with 62% of their caseload derived in 1994/95 from the Hamilton-Wentworth area, the population centre for the central west region. Some communities such as Waterloo Region and Haldimand-Norfolk are actually closer to the St. Thomas and London communities and residents access a variety of centres depending on their proximity to services and the nature of their service requirements.

Table 34: Mental Health Separations in Central West Ontario 1994-95

County/Region	Separations from Hamilton Psychiatric Hospital	Separations from the London/St. Thomas Psychiatric Hospitals	Separations from Other Psychiatric Hospitals	Total Separations from All Psychiatric Hospitals
Brant	29	5	2	36
Haldimand-Norfolk	22	112	0	134
Halton	30	2	8	40
Niagara	90	8	9	107
Wellington	2	22	5	29
Dufferin	0	2	10	12
Waterloo	2	180	7	189
Hamilton-Wentworth	408	13	4	425

Source: Ministry of Health (1994/95)

The central west counties/regions of Brant, Halton, Niagara and Hamilton-Wentworth almost exclusively receive their longer-term mental health care from the Hamilton Psychiatric Hospital.

The HSRC has learned that the Ministry of Health is working on a regional plan for longer-term mental health services which may seek to reconfigure current utilization patterns. A regional system design team for the central west planning region, consisting of representatives from relevant facilities (Hamilton Psychiatric Hospital, Homewood Health Centre, McMaster University, district health councils, and the Ministry of Health), looked at the design of the regional/tertiary elements of the mental health system examining outcomes. Their report⁹ provided clarity and guidance on:

- identification of functions that are to be provided at the regional level
- identification of the outcomes desired from regional services
- identification of linkages and cause and effect interrelationships among all functions and elements of the mental health system
- the activities/programs that will be required to deliver these functions.

The design team members approached system design as a contained planning exercise with a focus on the logic of what is needed regionally, and how it links to local services. Using this “logic model methodology”, the design team was forced to consider roles and functions of regional mental health services from the basis of future needs and desired outcomes, not influenced by the status quo. A report is expected in early 1998.

The HSRC cannot determine the full level of reinvestment required in community based on the planning by the DHC to date. Furthermore, the planning is inconclusive regarding the detail around regional mandates. The HSRC using its criteria, determines the location of both acute and longer term mental health beds. The result of application of the criteria is summarized in the following paragraphs.

Quality

Clinical Coherence

The HSRC has concluded that co-location of acute mental health services with full service acute care facilities is most appropriate and a distribution of acute services to various acute sites is the preferred option to enhance clinical coherence.

Hamilton-Wentworth is currently served by three Schedule 1 acute mental health sites, St. Joseph's Hospital, Henderson and McMaster sites of the HHSC. All sites are teaching units affiliated with McMaster's faculty of health sciences. The estimated 91 acute mental health beds will be located at St. Joseph's Hospital and the Henderson and McMaster sites of the HHSC.

⁹ Central West District Health Councils: Brant Haldimand-Norfolk, Halton, Hamilton-Wentworth, Niagara, Waterloo, Wellington-Dufferin. *Re-designing the Regional Mental Health System for Central west: Identifying and Clarifying the Role, Functions and Outcomes of Regional Mental Health Services* December 1996.

Critical Mass

With respect to longer-term mental health services, a significant consideration is the appropriate critical mass that will maintain a sufficient level of expertise. Although current practice patterns indicate that the Niagara region utilizes longer-term mental health beds in Hamilton, the HSRC is recommending that these be relocated to the Niagara region. According to planning guidelines, the Niagara region would require 53 longer-term mental health beds. Examination of recent cases indicates that Niagara would be able to support this complement of longer-term mental health beds. Locating longer-term mental health beds in Niagara would bring services for these patients and families closer to home. This program would build on the expertise of existing programs in the area; the local population can provide the critical mass required to support a longer-term mental health program. The HSRC will determine the location of beds that are to be allocated from Hamilton to Niagara when it studies services there.

Although Halton region has a similar sized population to Niagara, examination of data from provincial psychiatric hospitals (1994/95) indicates that the actual number of beds used for all Halton residents, at a 90% bed occupancy, was only 14. It may be difficult for such a small program to facilitate the recruitment and retention of specialized psychiatric personnel. For these reasons, Halton has been included in the population for planning for longer-term mental health beds in Hamilton.

Currently, all longer-term mental health beds in Hamilton-Wentworth, are located at the Hamilton Psychiatric Hospital (HPH), a provincial hospital owned and operated by the Ministry of Health to serve all of the central west planning region. The Health Action Task Force's (HATF) recommendation was to move these services to the HHSC-Chedoke site. The Hamilton DHC, in its report of May 1996, recommended the closure of the HPH and the transfer of its programs to another location.

Moving longer-term mental health programs from a stand-alone facility such as HPH to an acute hospital site improves the quality of these services. This consolidation of programs would increase the critical mass, to both attract and retain psychiatrists and improve support services coverage. An acute hospital site also has other advantages that would enhance the clinical coherence of these services: emergency services, in-patient acute mental health beds, and a full complement of medical/surgical coverage.

Hamilton-Wentworth will require 124 longer-term mental health beds to meet the needs of the residents of Hamilton-Wentworth, Brant and Halton. The HSRC considered options involving locating longer-term beds at each site of the Hamilton Health Sciences Corporation, or at St. Joseph's Hospital.

The HSRC's analysis shows that the longer-term mental health and forensic services should be located at St. Joseph's Hospital, improving the quality and accessibility of these services. The HSRC's conclusion is based on the following factors:

- St. Joseph's is located in the downtown core where supportive housing and after-care services are located.
- St. Joseph's is the regional emergency site for acute psychiatric services
- St. Joseph's offers a wide range of mental health care services. This includes Crisis Outreach and Support Team (COAST), the Hamilton-Wentworth HSO Mental Health Program, the Mood Disorder Program, Rainbow's End, East Region Mental Health Service (ERMHS), the Psychiatric Rehabilitation Services (PRS), the Peer Support Network, the Consolidated Schizophrenia Program and First Place Family Practice Medical Centre (FPFPMC).

Transferring longer-term mental health services to a full service hospital will increase the clinical coherence of these services and provides a continuum of care to meet patient needs.

Affordability

The closure of the HPH site and the co-location of its programs at St. Joseph's Hospital will result in overhead savings.

The HSRC estimated that the capital costs of locating the longer-term mental health program and forensic services at any Hamilton site would be similar since a new mental health pavilion would be required regardless of site.

Forensic Services

To maintain clinical coherence with longer-term mental health services the HSRC advocates the co-location of forensic services with the larger of the region's longer-term mental health inpatient programs. The 18 forensic beds used by minimum security patients at the Hamilton Psychiatric Hospital will be retained.

The HSRC acknowledges that this quantity of beds is relatively small for the population served by the Hamilton hospitals. Furthermore, while other, smaller communities like London and Kingston have a number of medium-secure beds, Hamilton does not have any such local program. The HSRC understands that the Ministry of Health is currently examining the sizing and distribution of forensic services for medium-security patients. The outcome of their review may affect on the number and type of forensic beds in Hamilton. The HSRC will await the outcome of the ministry review before making any further adjustments.

Child and Adolescent Mental Health

The HSRC has heard in several communities that the lack of paediatric mental health beds is an issue. *The Hamilton-Wentworth District Health Council Mental Health*

System Design Report (February, 1997) recommends that an eight-bed adolescent mental health unit be established. Currently there are no designated paediatric mental health beds in Hamilton-Wentworth.

In the absence of planning guidelines, it is difficult to determine how to best size for inpatient paediatric mental health services. As a preliminary step, the HSRC investigated current utilization of inpatient mental health beds within the province, looking specifically at those 0-17 years of age. Inpatient days from all acute care hospitals as well as designated adolescent programs from hospitals in Hamilton, Whitby and London, were included in the database. A provincial average of 7.56 beds per 100,000 population 0-17 was determined based on a 75% occupancy rate. Applying this ratio to the entire central west population of 0-17 year olds, 525,707 (1996), the required number of paediatric mental health beds would be 40.

Table 35: Child and Adolescent Mental Health Beds Required

Community	Beds	Population 0-17	Actual Beds Used (1996)
Brant	2	32,122	4
Haldimand-Norfolk	2	27,903	<1
Halton	6	85,686	6
Hamilton-Wentworth	10	114,740	6
Niagara	8	96,933	4
Waterloo	8	109,498	<1
Dufferin	1	13,311	<1
Wellington	3	45,514	<1
Central West Total	40	525,707	22

**excludes 7 transition to independence place*

Based on the above information, the HSRC will locate 17 child and adolescent mental health beds in Hamilton, at the McMaster site of the Hamilton Health Sciences Corporation to provide services to the residents of Brant, Haldimand-Norfolk, Hamilton-Wentworth and 50% of the Halton region.

Of the total of 40 beds required for the central west region, approximately 17 beds relate directly to populations served by the Hamilton hospital system. This includes the 10 beds directly related to the Hamilton-Wentworth paediatric population and the 6 beds planned for the Halton region. The HSRC will determine the location of the remaining 23 mental health beds when it studies services in the remaining counties in the central west region. In order to maintain critical mass, all 17 should be located as a single program. To further clinical linkages in the paediatric population, co-location with the paediatric acute care services at the HHSC McMaster site is the preferred option.

Table 36 summarizes the location of the acute, longer-term mental health and forensic beds in Hamilton-Wentworth:

Table 36: Siting of Acute and Longer Term Mental Health Services

Hospital/Site	Acute Mental Health	Longer-term Mental Health	Forensic Beds	Paediatric mental health beds
St. Joseph's	41	124	18	
Henderson	26	0		
General	0	0		
McMaster	24	0		17
Total	91	124	18	17

SECTION IX: GOVERNANCE AND MANAGEMENT OPTIONS

Overall Governance

Governance is a significant issue in all HSRC reviews. The 1992 report *Into the 21st Century*¹⁰ noted that governance responsibilities vary in scope between institutions and organizations providing an array of hospital-based services, but identified a set of common responsibilities including:

- to outline the purposes of the hospital, its goals, objectives, the hospital's mission, quality of patient treatment and care, relations with professionals, staff, the community and province, reporting relationships, public access and accountability
- to define and maintain the principles, value, culture and ethical environment of the hospital, its relationships to its patients, the communities it serves and the other providers and stakeholders
- to ensure the long-term fiscal and physical viability and integrity of the hospital
- to oversee the effective management and financial health of the hospital
- to ensure and monitor the quality of services in all aspect of hospital operations.¹¹

Governance structures should be representative of the communities served and reflect their demographic, cultural, geographic, ethnic, religious and social characteristics . The HSRC also recommends that some of the members on the new governance structure have prior experience and expertise in governing health services.

The HSRC considered two governance options to facilitate the provision of hospital services in accordance with the preferred siting option. The HSRC continues to be of the view that the specifics of the governance structure and its implementation are best developed locally. Governance models are available that satisfy the requirement for integration of health services and address cultural, linguistic, religious and ethnic considerations and requirements. It is the responsibility of local community leaders to explore and arrive at models that satisfy their particular circumstances.

The HSRC's decision-making with regard to governance is guided by the following principles:

¹⁰ *Into the 21st Century*. Ontario Public Hospitals Report of the Steering Committee, Public Hospitals Act Review: February 1992.

¹¹ Ibid.

- The tradition of voluntary governance has served Ontario communities well over the past century and should be maintained and enhanced in a restructured health services delivery system.
- There are significant benefits to be derived from the diversity, tradition and culture of the broad array of hospitals and health care organizations in the province.
- Diversity, tradition and cultural differences must not, however, stand in the way of the necessary shift from autonomy to interdependence, which will lead to more effective and efficient services for patients.
- The priority of governance structures must be to promote the development of interdependencies as the basis for a smoothly co-ordinated, strategically planned, functional system.
- There is no one “best” system/model of governance, but there is a need to find “better ways” to promote integration, efficiencies and effectiveness across the various components of the hospital and health care system.
- Models of new forms of governance should emerge that preserve and enhance the distinctiveness of the organizations and institutions involved while allowing each of them to contribute their strengths and talents to discharge their collective responsibilities.

The board of trustees for each hospital:

- must be representative of the communities served and reflect the demographic, cultural, linguistic geographic, ethnic, religious and social characteristics of Hamilton-Wentworth County.
- must embrace a fair and equitable process of nomination and election of community members to the board of trustees
- must facilitate the movement of patients, programs, staff, physicians and other materials between the hospitals in accordance with the HSRC directions
- must treat all employees at all affected facilities in a fair and equitable manner while HSRC directions are implemented.

In developing and considering options for governance, the HSRC considered the recommendations from the district health council, information gathered in written submissions and verbal representations, and the feasibility of and practicality of any option under existing corporate status and legislative requirements.

The governance options are discussed below in terms of the following criteria:

- their consequences on local hospital services
- their impact on the implementation of restructuring
- the ongoing effective and efficient management of the local hospital system.

The HSRC reviewed two governance options for the Hamilton-Wentworth hospital system.

Option one: a single hospital system board for all of Hamilton-Wentworth.

Option two: maintenance of existing acute hospital boards.

Option One builds on the model recommended by the Hamilton-Wentworth Health Action Task Force. A single board would assume responsibility for all hospital activities, and a single medical staff and management structure would be in place. Once implemented this governance structure would expedite the implementation of restructuring. This option would require transfer of assets to a successor organization that could be either of the two existing hospitals or a new corporation. Creation of a new corporation, and or the transfer of assets, would require the development of new structures, as well as the consolidation of senior and middle management and of medical staffs. These activities may distract from other restructuring activities.

Option Two represents the current governance structure in Hamilton-Wentworth. The two acute hospitals' governance and management structures would continue in their present form. There has already been significant consolidation of hospital services in Hamilton: the Hamilton Health Sciences Corporation is the result of the merger of four acute care hospitals (Henderson General, Hamilton Civic, McMaster and Chedoke). The St. Joseph's Hospital currently governs the provision of health care services on two sites; the main St. Joseph's Hospital in Hamilton and the Stoney Creek ambulatory care facility. Under this option there would be two acute care boards, each providing a significant portion of health care services in Hamilton-Wentworth. There may be a risk that having two separate governance structures will delay implementation of the HSRC's directions. However, there is evidence of co-operative planning efforts in Hamilton-Wentworth through their joint liaison committee and through the Academic Health Care network. These forums have had a positive influence on planning in Hamilton. Since there is evidence of cooperative planning in Hamilton, the HSRC does not find a compelling reason to change the existing acute hospital governance structures in Hamilton-Wentworth.

The HSRC wants to ensure that the implementation of restructuring achieves an optimal configuration of health services, fully integrated and linked in the local health system. The joint liaison committee has had some success in joint planning. The HSRC believes that this committee should be strengthened to ensure the expeditious implementation of HSRC directions. In communities where there has been a history of joint activities such as London and Essex, the HSRC has required the hospitals to empower a joint executive committee with the responsibility to implement the HSRC directions. These committees are time-limited bodies with specific authority regarding restructuring matters. To ensure that the restructuring of the Hamilton-Wentworth health system is accomplished smoothly and effectively, the HSRC will

require that the two Hamilton-Wentworth hospitals establish a joint executive committee to implement the directions of the HSRC.

The joint executive committee (JEC) will have equal representation from the three hospitals, and a representative from the district health council, from McMaster University, HPH Community Advisory Board and the CCAC. It will be in place for two years from December 31, 1997 to December 31, 1999. Each of the three hospitals will appoint the members of the executive committee of its board of directors to the joint committee, delegating to them decision-making authority on matters relating to the operation of its hospital, including:

- the restructuring of hospital services, the allocation of services and the continuum of care provided to patients
- the implementation of a plan that will address the impact of hospital restructuring
- the financial and operating plans for the hospitals
- the development of regional shared administrative and laboratory plans
- opportunities for the appropriate integration of shared services to reduce unnecessary duplication.

Recommendation

The two existing governance structures--the Hamilton Health Sciences Corporation, for the Henderson, Civic and McMaster sites, and St. Joseph's Hospital for both the St. Joseph's Hospital and the St. Joseph's Health Care Center sites--should be maintained. The two boards and St. Peter's will appoint members to a joint executive committee and delegate to the joint executive committee the powers to make decisions on behalf of the hospital in order to implement the directions of the HSRC.

Regional Rehabilitation Network

The HSRC supports a regional rehabilitation network led by the Hamilton Health Sciences Corporation, as it will be the regional rehabilitation facility for central west. This network would work towards an integrated program approach for rehabilitative services and be responsible for:

- ensuring coordination of and equitable access to rehabilitation services in Hamilton-Wentworth
- establishing linkages among the regional inpatient rehabilitation providers, and acute care facilities in Hamilton-Wentworth, Brant, Niagara, Wellington, Haldimand-Norfolk, Burlington and community-based rehabilitation providers in Hamilton-Wentworth
- examining opportunities to reduce duplication in administrative overhead, research and direct service delivery

- recommending siting of the seven transition to independent living spaces in collaboration with community-based providers
- determining, in collaboration with the Community Care Access Centres (CCACs), the appropriate mechanisms for delivering in-home rehabilitation services and developing a performance evaluation mechanism for the regional rehabilitation services system based on quality and access indicators

Governance and Management of Mental Health Services

The Hamilton-Wentworth District Health Council released its *Mental Health System Design Report* in February, 1997. In this report a number of recommendations are made to improve the co-ordination and integration of mental health services with primary, continuing and acute care services. The need for a co-ordinating mechanism for the mental health system was also identified.

In some communities the HSRC has recommended to the Minister of Health that on a short term basis regional mental health agencies be established to co-ordinate and manage the implementation of restructuring of mental health services, including the ability to redirect programs and funding. The HSRC's objective is to ensure a body is put in place with the ability to take action and ensure that the process of rebalancing mental health services proceeds expeditiously and encompasses the full spectrum of services and supports for the seriously mentally ill. The HSRC's objective is for the agencies to direct the location and type of programs and funding, allow the agencies to respond quickly to changes required during the restructuring process and ensure ongoing access to quality programs.

However, the HSRC is concerned that such structures have not been established and no effective alternative mechanisms are either in place or proposed to co-ordinate the implementation of restructuring which has already begun in many communities.

The HSRC is interested in receiving advice on other mechanisms and approaches that could be put in place decision making processes to co-ordinate and advise on the implementation of mental health services restructuring, locally or regionally; and affect funding and program decisions necessary to support implementation. The HSRC is interested particularly in options that involve directly both institutions and community-based organizations in the coordination process.

Pending the closure of the Hamilton Psychiatric Hospital or the transfer of its programs and services, the governance and management of mental health services at the Hamilton Psychiatric Hospital will be provided by St. Joseph's Hospital.

Child Health Network

To facilitate the co-ordination of planning and delivery of children's health services between sectors it is necessary to develop and implement a co-ordinating mechanism. It is the view of the HSRC that paediatric and adolescent services should be co-ordinated in planning and delivery through the establishment of a paediatric care network led by the Hamilton Health Sciences Corporation. The paediatric care network should have as its mandate:

- to plan for levels of children's health care services that are appropriate to the needs of the population
- to examine opportunities to reduce duplication in administrative overhead, research and direct service delivery
- to develop appropriate care maps and clinical pathways that span hospital and community services
- to develop and implement appropriate information systems and technology, in co-operation with other providers, and facilitate a common information system for all providers
- to monitor the delivery of services
- to serve as the paediatric component for McMaster University teaching and research, and
- to enhance linkages with other services for children and adolescents.

This network should be established immediately. In the short term, in order for the HSRC to monitor its activities, it should provide regular quarterly reports to the HSRC, the Ministry of Health and local providers.

The leadership role to be played by HHSC is viewed as transitional. Once the network is fully functional, HHSC would be a significant participant but the network would develop its own mission and values to be shared by all participants.

Integrated Academic Health System

In its submission to the HSRC the St. Joseph's Health Care Society (SJHCS) and the Academic Health Care Network advocated for the creation of an integrated academic health system (IAHS) in the central west region of Ontario.

St Joseph's Integrated Academic Health System

The proposed IAHS would have a rostered population of approximately 100,000 by the end of the three-year pilot project. Geographically, the IAHS would provide

services in Hamilton-Wentworth and Brant counties, which have a population in excess of 600,000. The pilot is intended to provide a comprehensive continuum of care including primary care, acute care, longer-term care and community services.

Services identified for inclusion in the pilot include:

- Comprehensive primary care and specialty physician services
- Home care and homemaking
- Long-term care including palliative services and supportive housing services
- Drug benefits
- Chronic care and rehabilitation
- Transportation
- Tertiary level-acute inpatient outpatient and emergency care
- Ambulatory care services and centres including urgent care
- Laboratory and diagnostic services.

The St. Joseph's Health Care System provides a base for the proposed IAHS since it provides care in Hamilton-Wentworth and Brant in a variety of formats.

Home Care/Homemaking

- St. Elizabeth Visiting Nurses

Acute Care

- St. Joseph's, Hamilton
- St. Joseph's, Brantford
- St. Joseph's, Guelph
- St. Mary's, Kitchener

Ambulatory Care

- St. Joseph's Community Health Centre, Hamilton

Chronic Care/Rehab

- St. Joseph's, Brantford
- St. Joseph's, Guelph

Long-Term Care

- St. Joseph's Villa, Dundas
- St. Joseph's, Guelph

The existing SJHCS provides a substantial number of services including some availability of acute, long-term care, rehabilitation, and home care/homemaking, and has the commitment of a number of primary care physicians. However, based on the evidence available the HSRC believes that this proposed IAHS project is in an early stage of development. Unlike Windsor's proposed IHS, the St. Joseph's IAHS

proposal recently reviewed by the HSRC lacks committed support from the district health council, the university or a broad base of community agencies.

Conceivably there may be more than one integrated health system serving Hamilton-Wentworth; the HSRC believes that there should be a thorough exploration of the issues surrounding the creation of more than one IAHS for Hamilton-Wentworth before proceeding with further planning. The HSRC has investigated integrated systems to promote a more systematized approach to health care that avoids “silos” of care and decreases destructive competition in the provision of health care for all Ontario residents.

Recommendation

The HSRC believes that planning for an IAHS in Hamilton must include as participants the university, the Academic Health Care Network the district health council and all academic hospitals in Hamilton. The HSRC therefore recommends that the district health council should take a lead role in the development of a plan for an integrated academic health system in Hamilton. The excellent work done by the St. Joseph's Health Care System and the Academic Health Care network should serve to expedite the process.

SECTION X: LONG-TERM CARE

Long-Term Care

The HSRC considers the broad spectrum of long-term care to include chronic care hospitals, chronic units in acute care hospitals, nursing homes, homes for the aged, supportive housing, long-term home care, attendant care and adult day care.

There were 2,479 beds in 18 facilities in the Hamilton-Wentworth area in 1995/96. The number of long-term care beds per 1,000 population aged 75+ was 87, compared to the provincial average of 101.

The HSRC is aware of waiting lists for long-term care facilities and the significant number of people currently awaiting services. It must be recognized that waiting lists are not an accurate measure of need since there can be a number of reasons for being on such a list (e.g., awaiting transfer from a long-term care facility to another preferred facility or anticipating a future need for services).

In Hamilton-Wentworth, the waiting list for long-term care facilities had 843 applicants (as of September 1997). Table 37 shows that 24% of applicants are waiting within the community while the remaining 76% are waiting from some other type of facility, including those who have already been placed into long-term care but are waiting for their facility of choice.

Table 37: Locations in Which Applicants to Long-Term Care Facilities Are Waiting*

Waiting From:	Community	Another LTC Facility	Acute Care	Chronic Care Facility	Other Institutions	Total
Cases	203	256	133	23	228	843
% of Total	24%	30%	16%	3%	27%	100%

*Hamilton-Wentworth

- The principal planning region for long-term care services includes all of Hamilton-Wentworth. The population projections for residents aged 75 and older in this planning region are shown in table 38 at right.

Table 38: Population Projection, Residents Aged 75+ in Hamilton-Wentworth	1995	2003	% change
Total Population	27,255	38,377	40%

Source: Ministry of Finance, Population Projections

- The planning horizon for the work of the HSRC is 2003. This is consistent with the planning horizon of the Ministry of Health. The HSRC regards the period from the present to 2003 as a reasonable interval in which to project the need for, and the appropriate size of, long-term care services within the broader health services system.
- The term “long-term care places” includes long-term care beds in nursing homes and homes for the aged, supportive housing, long-term home care, attendant care and adult day care. Based on a planning range of 206.0 to 243.1 long-term care places, Hamilton-Wentworth will need an additional 2,338 places by 2003. These are distributed¹² as follows:
 - 1,127 long-term care beds in nursing homes or homes for the aged
 - 1,210 places in supportive housing, long-term home care, attendant care and adult day care.

Table 39 illustrates the current and proposed sizing for complex continuing care and long-term care spaces for Hamilton-Wentworth.

Table 39: Impact of the Proposed Planning Guidelines on the Distribution of Long-Term Care Services in Hamilton-Wentworth

	Current beds/ spaces 1995	Proposed beds/spaces to 2003	Change	
			#	%
Complex continuing care	485	269	(216))	44% decrease
Long-term care	2,479	3,606	1,127	45% increase
Supportive housing/long-term home care	3,853	5,063	1,210	31% increase

Adding long-term care beds in a particular region is an issue that will have to be assessed locally based on the current configuration of long-term care services. For planning purposes, the HSRC has identified in its reports the level of reinvestment for operating costs required to provide additional long-term care beds in each region. This reinvestment will have to be evaluated against the broader configuration of long-term care services.

¹² Although the HSRC's research concludes that of the 3,606 long-term care places required, 2,479 should be institution-based, it is difficult to estimate the exact proportion of nursing homes and homes for the aged, given that current utilization likely does not reflect either desired or appropriate use of nursing homes and homes for the aged.

The HSRC's preference is for increased long-term care in community-based settings (supportive housing, long-term home care, attendant care and adult day care) rather than institution-based settings (nursing homes and homes for the aged). However, it is unrealistic to assume that an increase of 2,338 long-term places by 2003 can be accommodated solely in these community-based settings. Some of the increased need will require additional institution-based capacity. Although the HSRC's research concludes that of the 2,338 long-term care places required, 1,127 should be institution-based, it is difficult to estimate the proportion of nursing home and home for the aged beds required given that current utilization of these beds does not necessarily reflect appropriate use of these beds.

Sub-Acute Care Beds

As noted in the HSRC discussion paper, the definition of sub-acute care is care for the patient who does not require acute services but is not yet ready for discharge to his/her home and community and may require separate and distinct inpatient services such as skilled rehabilitation or nursing. Such patients are expected to recover completely over time, but cannot be discharged immediately to their homes as they need assistance with activities of daily living and lack the necessary supports at home.

Based on the proposed age-weighted ratio of 0.14 beds per 1,000 population, 99 sub-acute care beds will be required in 2003.

The HSRC welcomes advice and representations on the most appropriate location of sub-acute programs. The HSRC will also consult with the Hamilton-Wentworth District Health Council on the best option for siting sub-acute care beds.

SECTION XI: RESTRUCTURING IMPACT--SAVINGS, COSTS AND REINVESTMENTS

Estimated Operating Savings from Restructuring

The purpose of this section is to outline potential costs and savings and reinvestment requirements in Hamilton-Wentworth hospitals. Costs and savings estimates are based upon data readily available to the HSRC.

A number of qualifications must be made regarding the estimates of costs, savings and reinvestment:

- The data used in the analysis are mainly 1995/96 values. The estimates do not take into account costs related to future inflation or other factors. Also, there have been changes in the Hamilton-Wentworth hospitals as a result of funding reductions and these are not reflected in the 1995/96 data.
- The savings are estimated on the basis of total expenses and do not address revenue fluctuations from implementation of the selected options.
- Data were not available in detail or were available only in an aggregate form for a great deal of hospital inpatient and ambulatory activity, as well as for community-based services. As a result, further analysis and differentiation of costs and activities will be needed to refine the estimates.
- Where cost data and/or methodologies were unavailable, estimates of costs were based on provincial average cost data.

The estimates are needed to assess potential costs, savings and reinvestment in Hamilton-Wentworth hospitals to evaluate options regarding sizing and location of services. Hospitals, the Ministry of Health and others involved in the development and assessment of detailed planning and implementation activities must refine the estimates using more complete and current information.

A number of categories of savings are associated with restructuring. They relate to clinical efficiencies, administrative efficiencies, restructuring savings from program transfers and reduced activity, and savings from consolidation and centralization of support services. The initial costs and savings methodology was provided by the Ministry of Health.

With the availability of more current data (1995/96) and to improve upon the costs and savings approach utilized in the initial restructuring reports, the HSRC undertook an extensive review of the methodology. Further research and analysis were conducted, both internally and with the assistance of the Ontario Case Costing Project. The Commission solicited input from the JPPC committees, working groups and task forces and from the staff of the Ministry of Health. The HSRC also conducted a focused single-session review with consulting firms and individuals

experienced in the field of hospital operations. This resulted in changes and refinements to the initial costs and savings methodology as outlined in the Thunder Bay, Pembroke, Sudbury and Lambton restructuring reports. A detailed description of the revised methodology is presented in the HSRC *Costing Methodology Technical Paper*, a summary of which appears in Appendix E. This paper will be issued for review and will be subject to further refinements.

Savings

Summary of Savings Estimates

The following summary outlines the savings associated with the restructuring recommendations after discounts for clinical efficiencies. As was done in other parts of the report, figures are reported to the nearest dollar and further rounded, for inclusion in notices of intent to issue directions to the hospitals and advice to the Minister.

Table 40: Summary of Total Expenses and Savings

1995/96 NET EXPENSES *	\$604,150,260	
<i>Clinical efficiencies</i>	(\$34,496,246)	
<i>Program transfers</i>	(\$1,954,286)	
<i>Support services efficiencies</i>	(\$10,980,627)	
<i>Administrative efficiencies</i>	(\$30,422,518)	
<i>Site closure</i>	(\$3,906,785)	
<i>Change in selected expenses¹³</i>	(\$386,241)	
<i>Complex continuing care savings</i>	(\$18,106,378)	
TOTAL SAVINGS	\$100,253,080	- 16.6%
REVISED EXPENSES	\$503,897,180	

**Net Expenses from OCDM*

For calculation purposes the 1996/97 allocation reduction will be applied as an improvement in clinical efficiency. In sum, the total estimated savings amount to \$100.3 million which represents 16.6% of net 1995/96 expenses.

Complex Continuing Care Savings

According to 1995/96 expenditures and using an occupancy rate set at 95%, the HSRC estimates the savings associated with reducing the complex continuing care beds from 485 (MOH, 1995/96) to 269 is approximately \$18 million, a 40% savings from current expenses.

¹³ Selected expenses are overhead expenses not transferred to the receiving institutions during program transfers.

The HSRC will advise the Minister of Health that funds saved as a result of reducing the number of complex continuing care beds be reinvested into long-term care (homes for the aged and nursing homes) in the Hamilton-Wentworth region.

Human Resources Impact

The restructuring of hospital services in Hamilton-Wentworth will have a significant impact on care providers and workers within the health system. The Hamilton Hospitals, including Hamilton Psychiatric Hospital, in conjunction with employee representatives will need to develop a comprehensive labor adjustment plan.

The impact of restructuring on medical manpower needs to be addressed through a structured approach. It is not the HSRC's intent to require that medical manpower plans be developed; the HSRC objective is rather to facilitate the development of an approach to this area. The HSRC recognizes the complexity of this task, but believes it must be pursued in the interest of both patient care and medical practitioners.

Estimated Reinvestments To Address Restructuring

Reinvestment in other health care services to compensate for the improvements in clinical efficiency in the hospital system and the reduction in services from the hospitals will be needed to support restructuring and the changing roles of the facilities.

The following estimates are based on benchmarks that have been established in previous reports. The HSRC is involved in ongoing research, re-examining the current methodology for determining reinvestments. This research is expected to better predict the nature and amount of reinvestment based on population-based planning ratios. The following reinvestment estimates will be adjusted to reflect the new guidelines once they are available.

Long-Term Care

There is an identified need for long-term care beds in the Hamilton-Wentworth region. If the number of long-term care beds were increased incrementally to match the provincial average and keep up with population growth, the approximate number of beds required for 2003 would be 1,127 beds and 1,210 placements for a total cost of \$21 million. The HSRC wants to make it clear that investments in long term care must be made prior to any reduction in complex continuing care beds

As noted earlier, the HSRC is currently involved in research to examine all long-term care services. Once this is concluded, the HSRC will re-examine long-term care requirements in the Hamilton-Wentworth region and make its recommendations.

Sub-Acute Care

The details regarding the costing of both transitional and sub-acute beds remain to be established. In the interim, it is anticipated that 99 sub-acute beds will be required. The range of nursing and personal care for these patients will range from 3 to 3.8 hours per day, translating into a reinvestment of \$7.1 million dollars. These beds will be funded on a programmatic basis, not a per diem basis.

Home Care

The effect on home care services as a result of shortened length of stay in the acute care setting, more aggressive utilization management and increased levels of day surgery is currently being studied.

The clinical efficiency savings derived from an average length of stay (ALOS) reduction to the 25th percentile efficiency level result in a savings of 117,682 conservable days for the Hamilton-Wentworth acute care hospitals. The methodology used in previous reports assumed that each day conserved in ALOS reduction and day surgery case conversions would add a 0.8 visit to home care services. Further, an estimate of \$40 was used as the average home care visit. This translates into a reinvestment of \$3.1 million for home care services in the Hamilton-Wentworth region.

Information Systems and Technology

Recognizing in 1992 that the lack of integrated information systems among providers contributed to duplication and fragmentation of services, an initiative called Wentworth Web was initiated to support information flow by e-mail to health professionals in the Hamilton-Wentworth area. In 1994 the name HappIN was coined for this Hamilton Area Public and Private Information Network.¹⁴ Since 1994, HappIN has been building a community support network for the health care partners in Hamilton-Wentworth, working through five pilot projects to support the integration of health communications. Examples of the projects include: the improvement and implementation of e-mail services; the design of a common patient booking system; informatics education and workshops; access to hospital records and access to clinical information sources.

¹⁴ HappIN Operating Plan, October 1997.

The proposed system would link the HHSC, St. Joseph's Hospital, St. Peter's Hospital, the university, the physicians and the community providers. A business case for the project has been developed and indicates a need for a one-time capital investment of \$2.4 million. This capital investment will cover computer equipment, peripherals and network/cabling. The annual operating expenses associated with the information network project are \$0.8 million.

The proposed improvements in information systems, information technology, enhanced telemedicine potential and improved communications is strongly supported in Hamilton-Wentworth. Such systems developments are essential for movement towards an integrated delivery of care to patients regardless of setting. The Ministry of Health is developing policy and process around these types of systems and some reinvestment will be required to develop them fully. Reinvestment in this technology will pay dividends in the longer term in both the quality and the efficiency of care. The HSRC supports the view that comprehensive clinical information systems are essential to the development of integrated systems.

Summary of Required Reinvestments

Table 41 provides a summary of reinvestments that the HSRC has determined are required to address restructuring.

Table 41: Summary of Required Reinvestments

Acute care- Level III neonatal ICU beds	\$2.8 Million
Home Care	\$ 3.1 Million
Long-Term Care	\$21 Million
Sub-Acute Care	\$ 7.1Million
Mental Health	\$1.4 Million
Rehabilitation	\$0.3 Million
Information Technology System	tba
Total	\$35.7.Million

Capital Investment

The HSRC believes that to achieve the goals of restructuring, significant reinvestment must be made in the local health system. The infrastructure needed to support the future of health care must be solid. The HSRC, through its advice to the Minister, is recommending an unprecedented capital renewal program across the province. These capital funds, used to upgrade and expand hospital buildings, will create the foundation necessary to meet the acute care needs of our population well into the next millennium.

Approach to Developing Capital Cost Estimates

Based on consideration of the information provided by the facilities, as well as the DHC's analysis, each of the current sites was assessed to determine its functionality, the physical state of the buildings and services, and the potential for expansion. In addition, each site was assessed to determine its potential for accommodating the number of beds and related patient activity in each of the options.

Capital estimates incorporate the impact of the restructuring plan and do not address other issues of facility reconfiguration or facility maintenance. Less costly alternatives should be explored as part of the development of any capital project.

The HSRC has applied the following approach to developing capital cost estimates:

- Based on the analysis of each facility's information provided by the facility and in the DHC's review, each of the current sites is assessed to determine its functionality, physical state of the buildings and services, and expansion potential.
- Each site is assessed based on the HSRC's sizing analysis to determine its potential to accommodate the number of beds and related patient activity in each of the options identified.
- Renovation and new construction costs, as well as related ancillary, site development and furnishing and equipment costs, are assessed using current industry space standards and cost estimates.

A preliminary capital cost assessment was determined based on the hospital facility summaries of deficiencies and space constraints. The number of ORs and ICUs and the renovations required for emergency and ambulatory space for each option were also considered.

The capital estimates for the preferred option are discussed for each hospital site:

St. Joseph's Hospital

To provide for the total complement of clinical services including 619 required beds, the building would need new construction. The focus of this new construction would include a new pavilion for mental health services including acute, longer-term, forensic and other mental health program space. The estimated capital costs for this new construction amount to approximately \$17.6 million.

Renovation will be required for the expansion of the complex continuing care , surgical site integration , ambulatory care and emergency services expansion. It is expected that these renovation costs will amount to \$5.9 million.

Ancillary, site development, and new furnishing and equipment costs add \$12 million to the capital investment, for a total capital cost of \$33.5 million.

McMaster Site

To provide for the total complement of clinical services, including 353 beds, there is no need for new construction. Renovation will be required for the expansion of ambulatory care , emergency services, the paediatric, child and adolescent mental health, for 14 additional NICU beds, for the surgical suite and for displaced functions. It is expected that these renovation costs will amount to \$5.5 million.

Adding to this the ancillary costs at 23.2% and furnishings and equipment allowance brings the total estimated capital cost of the McMaster site to \$9.7 million.

General Site

To provide for the total complement of clinical services, including 402 beds, the building would need new construction. The focus of the new construction would include rehabilitation beds and expanded rehab services. The estimated capital costs for this new construction amount to approximately \$4.4 million.

Renovation will be required to convert acute beds to rehab beds as well as to expand the ambulatory care services at an expected cost of approximately \$1.6 million.

The ancillary costs at 23.2% and the furnishings and equipment allowance bring the total estimated capital cost of the General site to \$8.5 million.

Henderson Site

To provide for the total complement of clinical services, including 351 beds, the building would have to be expanded by approximately 211,116 square feet; Capital will be required for the construction of a new pavilion of complex continuing care beds; Estimated new construction costs will amount to \$10.1 million.

Renovations will also be required for the expansion of the ambulatory care , emergency services, and displaced functions. It is estimated that renovations to these areas will amount to \$2.3 million. With the addition of \$6 million for ancillary costs, site development allowance and furnishings and equipment, the total capital investment for this site amounts to \$18.3 million.

Total capital investment estimated to support the recommended siting option amounts to \$72 million. See Appendix F: Capital Investment Estimates

The capital estimates break down as follows:

Table 42: Summary of Capital Reinvestment for Hamilton Hospitals

	St. Joseph's	General	McMaster	Henderson	Total
New construction	\$17.6 M	\$ 4.4 M	\$ 0M	\$ 10.0 M	\$ 32.1 M
Renovations	\$5.9 M	\$ 1.6 M	\$ 5.5 M	\$ 2.3 M	\$ 15.4 M
Ancillary costs	\$5.4 M	\$ 1.4 M	\$ 1.3 M	\$ 2.9 M	\$ 11 M
Site development	\$1.3 M	\$ 0.2 M	\$ 0 M	\$ 0.5 M	\$ 2.0 M
Furnishings & equipment	\$5.2 M	\$ 0.9 M	\$ 2.9 M	\$ 2.5 M	\$ 11.5 M
Total capital estimates	\$35.5 M	\$ 8.5 M	\$ 9.7 M	\$ 18.3 M	\$ 72 M

SECTION XII: SUMMARY OF RECOMMENDATIONS

Adult Acute Care

The recommended option for the siting of all hospital services utilizes the existing capacity at St. Joseph's Hospital including the St. Joseph's Health Care Center and the McMaster, General and Henderson sites of the HHSC. This option also requires that the following sites cease to operate as hospitals: Hamilton Psychiatric Hospital, St. Peter's Hospital and the HHSC-Chedoke site.

The acute inpatient activity estimates are based on achievement of utilization improvements and growth in population served to the year 2003.

The emergency and ambulatory caseload is apportioned to the remaining sites in relation to the existing caseload and projected inpatient activity.

The intensive care/coronary care capacity currently utilized is maintained and follows the movement of clinical activity from closed sites to remaining sites under the recommended option.

Operating rooms required to perform at the revised activity levels are assessed for each site.

Respirology

The program lead and concentration of critical mass will be St. Joseph's Hospital.

Oncology

The Henderson site will be maintained as the host hospital for the Regional Cancer Centre and its focus in oncology will be enhanced.

Paediatric Acute Care

The current McMaster site of the HHSC is maintained and enhanced by consolidating all paediatric inpatient and outpatient services to this site.

Neo-Natal Intensive Care

Level III neonatal intensive care resources are increased at the McMaster site. Level II neonatal intensive care will be maintained at both the McMaster and St. Joseph's sites to reflect current and expected occupancy.

Child Health Network

The HHSC will lead in the development of a Child Health Network to provide for improved planning and co-ordination of paediatric services, including paediatric mental health.

Complex Continuing Care

The recommended option for chronic continuing care is to transfer the provision of these services from Chedoke and St. Peter's to the Henderson site of the HHSC and to St. Joseph's Hospital; the current program at HHSC McMaster site will be retained.

Hospital-Based Rehabilitation

Short- and long-term rehabilitation beds will be located at each hospital site and regional rehabilitation beds will be located at the General site of the HHSC.

Adult Acute Mental Health

Adult acute mental health services will remain at the existing three Schedule 1 adult acute care sites.

Paediatric and Adolescent Mental Health

This program will be located at the McMaster site of the HHSC.

Long-Term Mental Health

The long-term mental health and forensic beds currently located at the Hamilton Psychiatric Hospital will be transferred to and managed by St. Joseph's Hospital. This will mean the closure of the Hamilton Psychiatric Hospital. Savings realized from mental health restructuring will be reinvested in community mental health in the region.

Summary of Clinical Services Changes

Data contained in Table 43 compares actual bed numbers to those recommended.

Table 43: Summary of Bed Requirements & ORs

Bed Category	Hospital Bed Numbers	
	Actual (1995/96)	Recommended 2003
Acute*	1,387	898
Projected Growth**		162
Acute Mental Health	82	91
Paediatric Mental Health	0	17
Long Term Mental Health	193	124
Forensics	18	18
Complex Cont. Care	485	269
Rehabilitation	128	146
Sub-Acute/Transitional Care	-	99
Total	2,294	1,824
Operating Rooms	39	46

*includes ICUs **estimate only for purposes of sizing physical plant

Governance

With the exception of St. Peter's Hospital and the Hamilton Psychiatric Hospital, there will be no changes in governance of the current corporations.

Governance structures will be representative of the community and have regard to the linguistic, cultural, ethnic, religious and demographic characteristics of the community. Expertise and experience will also be taken into consideration in the development of governance structures.

The boards of the Hamilton Health Sciences Corporation and St. Joseph's Hospital will appoint members to a joint executive committee and delegate to it the powers to make decisions on behalf of the hospitals to implement the directives of the HSRC. The Hamilton Psychiatric and the St. Peter's Hospitals will also participate along with the Academic Health Care Network. Prior to the movement of the program the governance of the Hamilton Psychiatric Hospital in the interim will be transferred to the St. Joseph's Hospital.

Mental Health Implementation Coordination

To co-ordinate the planning, implementation and ongoing monitoring of mental health services in central west Ontario existing management structures will be used for a limited duration.

Integrated Academic Health System

Planning for an integrated health system is recommended for the Hamilton-Wentworth region, building on the excellent work already done by St. Joseph's Hospital and the Academic Health Care Network. They will participate in the development of an IHS plan undertaken under the auspices of the Hamilton-Wentworth DHC.

Child Health Network

Paediatric and adolescent services will be co-ordinated in planning and delivery through the establishment of a child health network initially led by the HHSC.

Costs and Savings - Operating Costs

The total expense budget for the Hamilton-Wentworth hospitals has been calculated to be \$604 million which achieves savings of up to \$100 million or 16% of total 1995/96 expenses.

Costs and Savings - Capital

Capital estimates for new construction, renovations, ancillary costs and equipment, amount to a total capital investment of \$72 million.

Reinvestments - Neonatal ICU

The HSRC supports the need for 14 additional NICU beds which will require \$2.8 million.

Reinvestments - Long-Term Care

To meet the need for institutional long term care population requirements, 1,127 long-term care beds will be required by 2003 at a cost of \$21 million. The HSRC reinforces its view that unless additional long term care beds must be in place before reductions to complex continuing care beds are made.

Reinvestments - Home Care

Home care visits will be added at a cost of \$3.1 million to respond to the clinical utilization improvements in the hospitals over the next three years.

Reinvestments - Mental Health

The savings in reducing the number of long-term mental health beds amounts to \$1.4 million and the HSRC recommends it be reinvested in the community.

Reinvestments - Sub-Acute Care

A reinvestment of \$7.1 million in sub-acute care is required in the region.

Reinvestments - Rehabilitation

An investment of \$0.3 million is required in rehabilitation care to meet the needs in this area by 2003.

The HSRC recommends reinvestment in the infrastructure and training needed to support the creation of a regional information system linking all health service providers in hospitals, organized group practices, community agencies and laboratories, in addition to private practitioners.

The estimated reinvestment requirements for the Hamilton-Wentworth region by 2003 is summarized in Table 44.

Table 44: Estimates of Reinvestment Requirements by 2003

Acute care-NICU beds	\$2.8 Million
Home Care	\$ 3.1 Million
Long-Term Care	\$21 Million
Sub-Acute Care	\$ 7.1Million
Mental Health	\$1.4 Million
Rehabilitation	\$0.3 Million
Information Technology System	tba
Total	\$35.7 Million

Additional Planning and Research

The HSRC is directing hospitals to commence planning in the following areas:

- labor adjustment
- support services consolidation
- information system integration

- governance.

The labor adjustment planning process will be assisted by a mediator appointed by the HSRC.

The HSRC is advising the Ministry of Health to commence planning in the following areas:

- integrated health system
- closure of the Hamilton Psychiatric Hospital.

The HSRC will perform additional planning and research in the following areas:

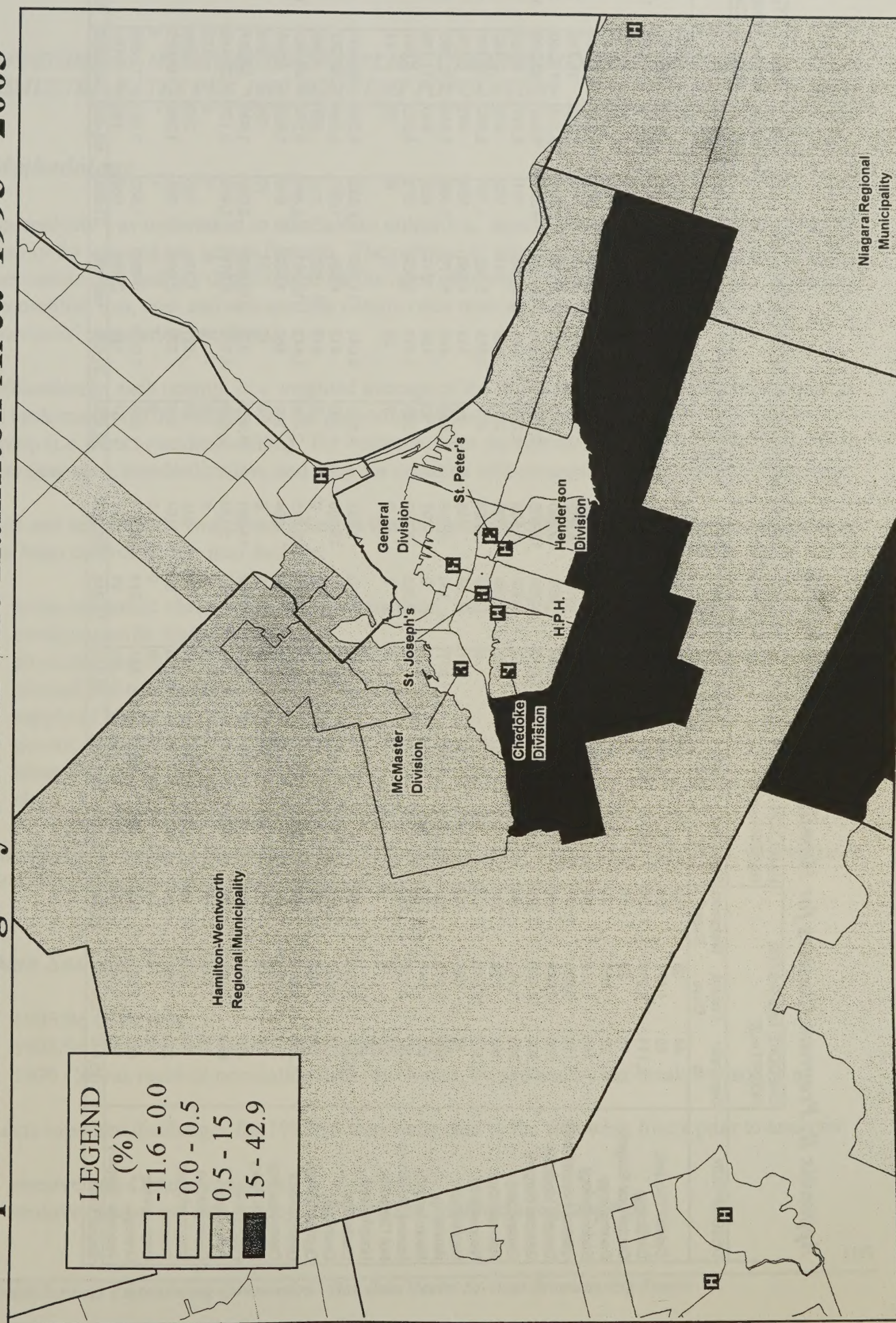
- transitional care/sub-acute care
- long-term and chronic care
- home care
- rehabilitation
- operating room planning
- estimation of growth in acute service activities.

The District Health Council and the Hamilton-Wentworth hospitals have already carried out a significant amount of planning over the past few years on how to best provide hospital services. The HSRC's decisions give a clear direction and designate an appropriate range of resources and opportunities allowing the community to advance with implementation and build a more integrated, co-ordinated and efficient hospital system for the residents of Hamilton-Wentworth.

The challenge that lies before Hamilton-Wentworth and other communities across the province is not to be underestimated. Managing the process of change at the community level will require the collective involvement and commitment of everyone who values our health system. The HSRC believes that its final directions will facilitate positive change in the hospital system, maintaining and improving patient care and addressing future financial challenges. The directions also establish a solid foundation for the system-wide integration of hospital services. The progress toward the unification of the hospital system will provide effective and efficient patient care for the residents of Hamilton-Wentworth.

The task will not be an easy one. The HSRC's vision is that the community will work together to bring about the changes necessary to create workable solutions to health care reform.

Appendix A: Population Change By FSA In The Hamilton Area 1995 - 2003



Appendix B: Program Clusters for Hamilton hospitals, 1995/96

DESCRIPTION	CHEDOKE MCMMASTER HOSPITALS			HAMILTON CIVIC HAMILTON GENERAL HOSPITAL			HAMILTON CIVIC HENDERSON GENERAL HOSP			ST JOSEPH'S HOSPITAL			Total Separations	Total Patient Days	Total Weighted Cases
	Separations	Patient Days	Weighted Cases	Separations	Patient Days	Weighted Cases	Separations	Patient Days	Weighted Cases	Separations	Patient Days	Weighted Cases			
Cardio/ Thoracic	44	58	18	26	64	15	3	19	4	72	121	36	145	262	73
Cardiology	63	1,471	338	1,671	15,106	6,576	25	497	104	357	3,851	1,139	2,116	20,925	8,156
Dental/Oral Surgery	1,111	6,210	1,490	2,446	13,488	3,314	1,446	10,968	2,336	1,777	13,330	2,951	6,780	43,996	10,091
Dermatology	18	29	10	7	17	4	10	16	5	7	18	4	42	80	23
Endocrinology	27	164	29	21	147	35	24	199	41	25	117	29	97	627	134
Gastro/ Hepatobiliary	248	1,174	261	132	1,840	298	143	1,322	219	502	2,578	569	1,025	6,914	1,347
General Medicine	1,160	6,030	1,142	677	4,476	800	737	4,066	727	959	5,164	1,019	3,533	19,736	3,687
General Surgery	548	2,929	556	431	3,091	586	409	5,285	881	785	5,935	1,036	2,173	17,240	3,058
Gynaecology	1,500	14,466	3,473	1,171	16,751	3,406	1,250	12,508	3,061	2,101	19,554	4,821	6,022	63,279	14,761
Haematology	388	1,472	404	13	71	15	1,092	4,466	1,283	684	2,713	761	2,177	8,722	2,462
Neonatology	184	739	216	44	281	56	136	928	227	109	544	152	473	2,492	651
Nephrology	1,333	13,646	2,436	0	0	0	494	3,456	407	1,853	8,365	1,197	3,680	25,467	4,039
Neurology	67	861	143	40	404	71	63	445	85	313	4,666	954	483	6,376	1,252
Neurosurgery	529	4,145	803	526	6,355	1,077	316	4,909	835	448	8,576	1,402	1,819	23,985	4,117
Normal Newborns	131	946	295	560	9,363	2,477	9	197	35	100	617	205	800	11,123	3,012
Not Generally Hospitalized	1,037	1,990	205	0	0	0	1,056	2,199	208	1,919	3,902	373	4,012	8,091	786
Obstetrics	6	6	2	1	2	0	3	3	1	29	33	8	39	44	10
Oncology	2,679	9,293	2,197	1	8	1	1,802	5,032	1,221	4,044	11,358	2,832	8,526	25,691	6,251
Ophthalmology	722	8,061	3,266	165	1,631	365	1,670	18,106	4,390	412	4,884	1,091	2,969	32,682	9,113
Orthopaedics	75	218	65	22	52	20	0	0	0	410	825	332	507	1,095	417
Otolaryngology	1,243	9,629	2,566	1,633	13,270	3,553	915	9,016	2,704	1,443	12,053	2,899	5,234	43,968	11,721
Plastic Surgery	317	711	242	113	496	134	106	394	102	486	1,902	639	1,022	3,503	1,117
Psychiatry	5	12	3	88	875	293	0	0	0	13	31	10	106	918	306
Pulmonary	453	9,239	1,065	72	1,455	208	390	11,601	1,455	975	14,952	2,062	1,890	37,247	4,790
Rehabilitation	863	5,085	1,094	560	5,565	988	527	5,178	970	1,175	9,815	1,932	3,125	25,643	4,984
Rheumatology	8	112	28	0	0	0	0	0	0	0	0	0	8	112	28
Trauma	45	359	63	28	350	61	26	240	38	121	1,320	186	220	2,269	349
Ungroupable	229	1,567	411	552	7,709	2,156	99	1,454	319	370	2,891	955	1,250	13,621	3,841
Urology	0	0	0	0	0	0	0	0	0	7	9	1	7	9	1
Vascular Surgery	421	2,063	501	364	1,851	424	574	2,874	695	1,022	5,866	1,582	2,381	12,654	3,201
Grand Total	15,647	104,653	23,940	11,773	108,994	28,315	13,346	105,655	22,420	22,690	148,650	31,856	63,456	467,952	106,531

APPENDIX C: METHODOLOGY APPLIED TO DETERMINE SEX AND AGE ADJUSTED RATES PER 1000 RESIDENT POPULATION

Methodology

An analysis was undertaken to standardize utilization, separation and acute expenditure rates by county for age and sex across Ontario. The purpose of standardization is to remove the effects of the various age and sex distributions on the rates of counties relative to the province. In order to accomplish this, age- and sex-specific county rates were applied to age- and sex-specific provincial population numbers.

Utilization in each county is a weighted average of the utilization of each of the age/sex groups in each county. The weights are the proportion of the provincial population in each age/sex group (i.e. direct standardization). For example, rates for counties with older populations would decrease upon standardization, and rates for counties with younger populations would increase.

Age and sex are only two of main factors that influence county rates. Other factors, which have not been controlled for, may include:

- socio-economic characteristics (e.g., education, income levels, ethnicity)
- county-specific disease rates
- physician supply
- clinical practice patterns
- supply of beds (e.g., rehab beds)
- genetic factors
- lifestyles
- etc.

The HSRC is currently researching the relationship of such factors on county rates, where data is available.

Data Sources

- 1995/96 CIHI data
- 1995/96 Ontario Cost Distribution Methodology
- 1996 Census resident population data (by county, by age and by sex breakdowns)

Acute inpatient discharges for 1995/96 were subjected to the following filters prior to analysis:

- remove non-Ontario residents
- remove newborns (entry code = "N" or HSRC defined age group = 7)

- remove psychiatric cases occupying Ministry of Health designated psychiatric beds (hospital type = “AP” with most responsible diagnosis as psychiatric)
- trim cases where length of stay is greater than 365 days and apply low severity per diem rate to trimmed cases.

Data was aggregated by age and sex using the PDST defined age groups (i.e., 0-14; 15-44; 45-64; 65-74; 75-84; and 85+ years).

Expenditures were estimated using average cost per weighted case (resource intensity weight) for each hospital.

Appendix D

***Guidelines for Clinical Scope of Perinatal
(Maternal/Newborn)
and Paediatric (Child/Adolescent) Services***

Submitted to

Health Services Restructuring Commission

THE METRO TONTO CHILD HEALTH NETWORK

September 30, 1997

The following guidelines were abstracted from the report of the Child Health Network to the Health Services Restructuring Commission. They are currently under review by the HSRC. The HSRC welcomes comment and feedback on the proposed guidelines, particularly with respect to their application beyond Metro Toronto.

Preamble to Guidelines for Clinical Scope of Perinatal Services (Maternal and Newborn Care)

The Perinatal Workgroup, consisting of representation from community, regional and tertiary hospitals, addressed the commission's directive for clinical service definitions and minimum requirements for Level I, II, and III neonatology services using three underlying network principles:

- a regional system of neonatal and paediatric care will provide the highest quality of care as close to a patients home as possible
- obstetric, neonatal and paediatric services need to operate in concert to achieve the highest quality of care within a regional system
- all hospitals offering obstetrical services need appropriate resources in order to manage acute cases that can not be anticipated in the antenatal period.

The attached criteria for Level I, II and III maternal and newborn services supports the concept of a regionalized system of care. It is an expectation of the Child Health Network, that each hospital will have regard for these criteria as stipulated. The criteria are to be interpreted as guidelines, and should not supersede the professional judgment of care providers. To achieve the highest quality of care within a regionalized system, it is imperative that Community hospitals and Regional Pediatric Centres in a designated region, function collaboratively and ideally as a single maternal, newborn and child care program. The Perinatal Workgroup feels this can be achieved using the following guiding principles:

1. Hospitals participating in a regionalized network must adhere to guidelines for the transfer of patients as well as minimum standards of care for mothers and newborns.
2. Each institution within the Network will contribute to the development of regional perinatal programs through the provision of four key elements:
 - i. patient care
 - ii. education
 - iii. monitoring & evaluation
 - iv. administration.
3. All hospitals providing obstetric services have the capacity to deal with unexpected complications or emergencies and to use appropriate referral and transport systems.

4. All hospitals will possess the skill sets to provide immediate resuscitation and stabilization of the newborn.
5. Anticipated moderate-risk maternal and neonatal patients should be treated at Level II units.
6. To ensure continuous quality improvement, appropriate resources must be invested to monitor and evaluate regional perinatal activities



LEVEL I (PRIMARY CARE)

Definition

The inpatient services in a Level I (primary care) perinatal unit should embrace the LDR/LDRP model of care. Facilities should have all the resources required to meet the needs of low-risk pregnancies where there is no predictable neonatal intervention required.

Maternal

Minimum Expectations for Level of Care

- ability to manage pregnancies where the mother has had no prior perinatal mortality or low birthweight infants, no significant medical disease, no significant pregnancy complications now or in the past, fetal growth seems adequate
- maternal-fetal assessment; to include identification of at risk pregnancies (with early consultation).
- ultrasound - capability for detailed anatomical scan in second trimester and biophysical profile
- availability of obstetric procedures/laboratory tests and diagnostic imaging
- provision of care for healthy mothers and their newborns with a gestational age at or over 36 weeks gestation and/or ≥ 2.5 Kg
- appropriate consultation with medical staff responsible for newborn care when anticipated obstetric or neonatal problems exist.

Treatments: Labour and Birth Area

- fetal monitoring available on a continuous basis
- IV available 24 hrs/day
- ability to perform a cesarean section within approximately 30 minutes
- manage pregnancy with one previous lower segment cesarean section

Newborn

Minimum Expectations for Level of Care

- care for the healthy newborn at or over 36 weeks gestation and/or $\geq 2.5\text{Kg}$
- observation and management of transient conditions (e.g. hypothermia, hypoglycemia responding to enteral feeds, respiratory distress with reducing or no oxygen requirement, hyperbilirubinemia)
- provision of newborn resuscitation according to the Neonatal Resuscitation: National Guidelines. This should include:
 1. a formal NRP program for all personnel who care for (or may care for) infants as part of their work responsibilities. These personnel may include ER medical and nursing staff, respiratory therapists in addition to perinatal medical/nursing/midwifery staff
 2. designation of an in-house neonatal resuscitation team at all times with clearly defined responsibilities. Of the two people available for resuscitation of the newborn as their sole responsibility in the delivery room, one must be able to intubate and administer fluids and medications
- stabilization, initiation and maintenance of assisted ventilation until transfer
- ability to accept transfers of infants including home births with conditions that are expected to resolve within a short period of time (e.g. breastfeeding establishment, phototherapy)

Treatments: Newborn

Availability of skilled individuals to perform the following treatments:

- continuous monitoring of: cardiorespiratory, O_2 saturation, non-invasive BP measurement
- O_2 therapy
- endotracheal intubation
- catheterization of umbilical vein
- venipuncture
- initiation of intravenous therapy

- lumbar puncture
- initiation of assisted manual or mechanical ventilation until transfer



Resources Required

Personnel within each Level I (primary care) facility

Obstetrics	- available within 30 minutes to initiate treatment
Anesthesia	- available within 30 minutes to initiate treatment
Paediatrics	- available within 30 minutes to initiate treatment
Nursing	- appropriately trained, available in-house 24hrs - 1:1 ratio when in active labour
Midwives	- available within 30 minutes to initiate care
NRP Team	- in-house 24 hrs (components of team may include family practitioner, ER physician, nursing, respiratory therapist, and/or physicians listed above)

Laboratory services available 24 hours in Level I (primary care) facilities

- blood gases
- serum electrolytes
- serum glucose and calcium
- serum bilirubin
- Coombs test/blood typing/cross match
- complete blood count and differential
- incubation of blood culture
- cerebrospinal fluid cell count

Diagnostic Imaging available 24 Hours

- stat portable chest x-ray
- obstetrical ultrasound

LEVEL II (SECONDARY CARE)

Definition

The inpatient services provided at Level II (secondary care) should have all the functional capabilities contained in hospitals that provide Level I care. In addition, Level II facilities should be equipped to meet and handle maternal-fetal patients of moderate-risk.

Maternal

Minimum Expectations for Level of Care

Consultation should be considered with an obstetrician and/or neonatologist/paediatrician in order to provide optimum care for the mother and/or newborn. These patients may be managed by continuing collaborative care and delivery in an obstetrical unit with a Level II neonatal unit, or they may be returned to the care of the referring caregiver with a suggested plan of management for the remainder of the pregnancy.

Ability to manage pregnancies that present with the following risk factors:

- diabetes, Class A (gestational) or Class B
- hypertension requiring drug therapy or with proteinuria
- renal disease without hypertension and without renal function impairment premature rupture of membranes or premature labour (≥ 32 wks)
- APH, single event and ceased
- twin pregnancy-two sacs
- cervical incompetence
- breech (36 weeks +)
- polyhydramnios
- primigravada (age 35+) or less than 16 years
- post-date pregnancy (10 days past dates)
- history of genetic disease in family (genetic amniocentesis or counseling required)
- history of prior still birth or neonatal death or premature delivery
- haemoglobin <90 g/L or haemoglobinopathy trait
- maternal obesity >100 kg at first visit
- significant tobacco, alcohol, drug intake
- grand multipara (>5)
- large for dates >90 percentile
- previous uterine surgery including Cesarean section
- other significant medical illness
- placenta previa ≥ 32 wks
- fetal anomalies not requiring immediate intervention

Maternal Intensive Care

ICU 24-hour capability:

- monitoring: oxygen saturation monitoring
ECG
invasive monitoring including S-G and arterial lines
- provision of ventilation
- ability to manage significant hypertension, hypotension and DIC

Neonatal

Minimum Expectations for Level of Care

- care for the healthy newborn
- availability of health care personnel trained in neonatal resuscitation available for every delivery, including the skill of intubation
- care of newborns born to mothers of Grade B risk
- resuscitation and stabilization of all neonates born in hospital
- initial and ongoing care for stable infants ≥ 1250 gm or ≥ 30 weeks gestational age
- care for moderately ill newborns who have problems that are expected to resolve rapidly including those transferred from level I or home birth.
- initiation and maintenance of short-term ventilation (24 hrs); mandatory consultation with a neonatologist for infants < 1500 g and notification of the Level III outborn facility for all ventilated infants

Treatments : Newborn

Availability of skilled individuals to perform the following procedures/ treatments:

- continuous monitoring of: cardiorespiratory status, O_2 saturation, transcutaneous O_2/CO_2 , non-invasive BP measurement
- endotracheal intubation
- catheterization of umbilical artery and vein

- venipuncture
- lumbar puncture
- initiation and maintenance of short term assisted ventilation
- administration of surfactant
- insertion of chest tube
- initiation and maintenance of intravenous therapy
- arterial puncture
- gavage feeding
- initiation, maintenance, and monitoring of total parenteral nutrition (TPN)
- administration and monitoring of low flow oxygen

- therapeutic drug monitoring

Transfer Criteria: Newborn

Consultation with a tertiary care centre which may lead to a transfer is required in the following situations:

- congenital malformations requiring special diagnostic procedures or surgical care
- increasing respiratory distress beyond 12 hrs of life
- infants failing to progress as anticipated
- infants with conditions requiring exchange transfusion

Ability to accept retro transfers from a tertiary centre of convalescing infants with the following:

- stable infants >1000g not requiring assisted ventilation
- infants demonstrating tolerance of full or increasing enteral feeding
- infants with chronic lung disease requiring oxygen therapy
- infants with apnea of prematurity requiring little or no stimulation
- infants with complex discharge planning needs
- infants at risk or showing evidence of retinopathy of prematurity

Resources Required

Personal within each Level II (secondary care) facility

Obstetrics 24 hours	-in-house/immediately available
Anesthesia available 24 hours	- in-house/immediately
Paediatrician/Neonatologist available 24 hours	- in-house/immediately
Nursing required	- to provide 1:1 NICU care as
labour	- to provide 1:1 during active
Respiratory Therapist available 24 hours	- in-house/immediately

Back-up System

- a formalized back-up system required for all personnel in-house 24 hours, in the event they are unable to respond to emergent calls.

Laboratory available 24 hours Level II (secondary care)

- blood gases
- cord blood gases · serum electrolytes
- serum glucose and calcium
- serum bilirubin
- Coombs test/blood typing/cross match
- complete blood count and differential · incubation of blood culture
- Cerebrospinal fluid cell count

Medical Imaging

- stat portable X-ray
- obstetric ultrasound - capability for detailed anatomical scan in second trimester and biophysical profile
- neonatal head ultrasound

LEVEL III - (TERTIARY CARE)

Definition

Inpatient services in a Level III (tertiary care) perinatal unit need to provide a full range of services from normal to high-risk maternal/ neonatal care.

Inpatient services in a Level III outborn neonatal unit (tertiary care) need to provide the full range of services for high-risk neonatal care.

Maternal

Minimum Expectations for Level of Care

High-risk pregnancies are those complicated to the extent that the fetus or the mother would benefit from tertiary care. Where doubt exists, appropriate consultation with a tertiary care facility should occur. Generally, these patients should be receiving care at a Level III (tertiary care) center for antenatal care and delivery.

Ability to manage pregnancies that present with any of the following Grade C risk factors:

- renal disease with hypertension +/- reduced function
- early uncontrolled premature labour (≤ 32 weeks gestational age)
- premature rupture of membrane (+/- sepsis) (≤ 32 weeks gestational age and ≥ 23 weeks antepartum bleeding, continuing or repeated (≤ 32 weeks gestational age)
- heart disease with symptoms
- haemoglobinopathy
- rhesus isoimmunization (with antibodies)
- fetal anomalies requiring immediate neonatal intervention

Based on the judgment of the care provider, treatment may be provided at a Level II perinatal centre with appropriate consultation:

- diabetes Class C, D, F, R, or significantly complicated (e.g. renal function impairment)
- severe hypertension with significant proteinuria
- severe fetal growth arrest (< 10 th percentile) and or oligohydramnious

Newborn

Minimum Expectations for Level of Care

Inborn units

- resuscitation, stabilization and ongoing care of all neonates born in hospital
- identification and timely transfer of infants with congenital malformations or other disorders who may require special diagnostic procedures, paediatric subspecialty consultation, or surgical care or consultation not available in facility
- acceptance of transfers of infants from level I or II units when appropriate within regionalized system

Outborn units

- provision of all required care for infants exceeding the capabilities of level I and II units
- provision of intensive care for neonates requiring re-admission after discharge from original hospital or after home birth
- acceptance of appropriate transfers from Level III inborn units (as defined in inborn units)
- coordination and management of timely and appropriate transfers of infants requiring Level III care
- for those infants requiring in-patient services (but not intensive care), The Hospital for Sick Children will continue to provide neonatal care for the downtown community of Toronto

Treatments

Inborn units

- the full range of non-invasive and invasive procedures/treatments required for maternal tertiary antenatal care and delivery including intensive care and including neonatal intensive care
- a full range of non-invasive and invasive procedures/treatments required for neonatal tertiary intensive care

Outborn units

- the full range of non-invasive and invasive procedures/treatments required for neonatal tertiary/quaternary intensive care and neonatal surgery

RESOURCES REQUIRED

Personnel within each Level III (tertiary care) facility

Obstetrics	- in-house 24 hours
Anesthesia	- in-house 24 hours

Neonatologist or designate	- in-house 24 hours
Nursing required	- to provide 1:1 NICU and labour care as
Respiratory Therapist	- in-house 24 hours
Back -up System	- a formalized back-up system required for all personnel in-house 24 hours, in the event they are unable to respond when an emergency occurs

PREAMBLE TO GUIDELINES FOR CLINICAL SCOPE OF PAEDIATRIC SERVICES(CHILD/ADOLESCENT)

The guidelines which follow have been informed by the work of the Implementation Workgroup, Emergency Services and After Hours Task Force and the Surgical Services Task Force.

These guidelines are consistent with the classification of Local/Community/Regional Paediatric Centre and Tertiary Centre - and the Commission's recommendation that in-patient paediatrics only be provided at Regional Paediatric Centres.

The age range for patients in the Child Health Network is 0 - 18 years. It is, however, recognized that exceptions do occur. A recommendation emerging from the Surgical Services Task Force was that, the nature of the procedure, the maturity of the patient and the wishes of the patient and family should guide decisions about exceptions. It is also noted that the age of the paediatric patient is 29 days to 18 years, with 0 - 29 days for infants requiring readmission within the first month of birth.

Through the work of the Emergency and After Hours Task Force it was confirmed that each community hospital have the capacity to provide acute care in an Observation Unit for up to approximately 24 hours.

The purpose of the Observation Unit shall be to provide *brief* periods of observation and treatment to children who cannot be discharged following an Emergency Department or Ambulatory visit. Those children whose observation or treatment can reasonably be anticipated to last more than 24 hours should be transferred at the outset to the appropriate Regional Paediatric Centre. The Observation Unit should not be considered a continuation of current in-patient capabilities and ideally, should be in close proximity to Emergency Departments.

Paediatric Age Range: 29 days to 18 years. Note: Includes infants 0 - 29 days who have been discharged from the birth hospital and who require readmission.

Local/Community Hospital

Clinical Scope

Minimum: Anticipatory guidance/prevention

Maximum:

- Ambulatory surgery for routine minor procedures in healthy children from 1-18 years at low risk for complications
- Capacity to stabilize major emergencies in the pediatric patient prior to transfer to a regional or tertiary centre e.g. cardiovascular and airway catastrophes
- Capacity to provide acute care in an observation unit for approximately 24 hours · Some components of care may be delivered at home
- Ambulatory clinics
- After hours clinic

Profile:

- Day Surgery
- Emergency Services including minor trauma e.g. sutures
- Observation Unit
- After Hours Clinic
- Linked to regional and tertiary facilities and community supports

Transportation:

- Stabilize patient and arrange for transportation to a regional or tertiary centre, as appropriate

Regional Paediatric Centre

Clinical Scope

Minimum: Anticipatory guidance/prevention

Maximum:

- Continuing (including in-patient) medical/surgical care for children from 0-18 years at moderate risk for complications within the scope of the medical/surgical support staff
- Continuing (including in-patient) child and adolescent mental health services
- OR available 24 hours per day
- Provision of care to children with conditions requiring the expertise of a multidisciplinary team within the scope of the clinical staff
- Provision of services to support the care of medical/surgical patients such as specialized pain management, TPN and moderately complex investigations
- Some components of care may be delivered at home.
- Care is provided to referred clients as well as to the local community. May provide non-tertiary provincial services e.g. pulse dye laser surgery

Profile:

- Day Surgery
- Emergency Services including moderate trauma
- Observation Unit
- Inpatient Medical-Surgical Unit
- Mental Health Facilities
- Ambulatory Clinics · After Hours Clinic
- Linked to local /community and tertiary facilities and community supports

Transportation:

- Coordinate transportation of patients from local/community facilities to regional centre
- Stabilize patient and arrange for transportation to tertiary centre, as appropriate

Tertiary Centre

Clinical Scope:

Minimum: Anticipatory guidance/prevention

Maximum:

- All levels of medical/surgical care for children 0-18 years
- Primary and secondary care provided to children of downtown Toronto
- Continuing medical-surgical care of children at high risk for complications, for children with serious illnesses.
- Some components of care may be delivered at home
- Provision of care to children with conditions requiring the expertise of a multidisciplinary team
- Provision of services to support the care of medical/surgical patients such as a Pediatric Intensive Care Unit and highly complex investigations.
- Care is provided to a broad range of referred clients as well as to the local community. (i.e. provincial services e.g. bone marrow transplantation.

Profile:

- Day Surgery
- Emergency Services, major trauma management
- Observation Unit
- Inpatient Medical and Surgical Units
- Pediatric Intensive Care Unit
- Ambulatory Clinics · After Hours Clinic
- Linked to local/community and regional hospitals as well as community supports

Transportation:

- Coordinate the transportation of patients from community or regional hospitals to tertiary centre
- Coordinate retrotransfers

APPENDIX E: SUMMARY OF REVISED COST SAVINGS ESTIMATION METHODOLOGY

The methodology described in this document is designed to produce estimates of savings related to four areas of hospital activity, as well as plant costs related to the implementation of restructuring:

- clinical efficiencies;
- restructuring savings (program transfer/program reduction);
- consolidation of support services;
- administrative efficiency; and
- site closure expenses.

While the cost savings estimates are advice to the Minister of Health, they have the potential of becoming guideposts or targets for costs and savings related to restructuring implementation. Therefore it is necessary to develop the best possible methods of estimation and use the most accurate information possible to guide decision-making respecting hospital and health care restructuring.

Due to the method of identifying costs and savings associated with various restructuring options the sequence of the estimates is fundamentally important to avoid double-counting and improve the accuracy in estimating costs and potential savings. The following is the sequence of steps respecting costs and savings estimates inherent in the methodology:

STEP 1: Determine Net Expenses

In order to establish the separation of direct service costs from indirect costs, the Ontario Cost Distribution Methodology (OCDM¹⁵) is applied. Net expenses are calculated in the OCDM by netting allowable recoveries/revenues and restructuring costs from gross expenses. Selected expense accounts (see table below) are deducted from net expenses to derive *adjusted net* expenses (includes plant, materials management and administration) for all patient types (i.e., acute inpatient and day surgery, chronic & respite, ELDCAP, palliative, rehab, outpatient, other hospital or community outpatients).

¹⁵ Detailed information about the Ontario Cost Distribution Methodology can be obtained from the JPPC Reference Document #RD4-6A, "Ontario Hospital Cost Distribution Methodology by Patient Activity", March 20, 1997.

<i>Account Code</i>	<i>Description</i>
71 7 10	Research - General
71 9 **	Marketed Services
81 9 50 80	Depreciation Undistributed - Major Equipment
81 9 55	Interest on Long Term Liabilities - Undistributed
81 9 60	Municipal Taxes
81 9 90	Other Undistributed Expenses - Operating
81 9 95	Employee Benefits - Debit Clearing Account
81 9 96	Employee Benefits - Credit Clearing Account
85 9 45	Other Undistributed Revenues
85 9 90	Other Undistributed Expenses
63030	Short Term Interest Charges
75000	Depreciation on Major Equip - Distributed
76000	Rental/Lease of Equipment
78000	Amortization - Software License and Fees
95080	Depreciation on Major Equip - Undistributed

STEP 2: Calculate Program & Related Transfers

In estimating savings for the transfer of inpatient acute clinical activity among facilities, a number of key assumptions were made:

- the latest current available levels of acute inpatient clinical activity (currently 1995/96 data) are used as a proxy for current clinical activity, as these are the latest data available;
- the most recent comparable equity formula estimates (currently 1995/96 data) of the costs per case are used as proxies for current cost per case, as these are the latest data available;
- the total outpatient/ambulatory and emergency activity is transferred at direct cost without differentiation between types of ambulatory care;
- costs for the transferring facility are estimated using **actual direct cost per case** for the hospital, multiplied by the number of weighted cases (inpatient or qualifying day surgery) to be transferred;

- costs of transferred activity are estimated at the *expected direct cost per case or the actual direct cost per case (whichever is lowest between the transferring and the receiving facilities)*, including all factor adjustments for tertiary, neonatal and teaching factors associated with caseload; and the difference between the cost for the transferring facility (actual direct cost per case) and the cost for the receiving facility (expected direct cost or actual direct cost - whichever is lower) is removed from the hospital system.

As a consequence of program transfers, there may need to be a reallocation of materials management expenses, based on the proportion of direct expenses of each reconfigured facility. No savings are generated in this step as these expenses are only re-distributed.

The number of weighted cases transferred may result in a *funding difference* in direct services if the transferred cost is lower than the actual cost of the transferring facility. Since there is no evidence to suggest that operating at a lower cost than the expected rate results in poorer services or outcomes it is the recommendation of the HSRC that the lower of expected or actual direct costs be used in the costing of transfer of programs between hospitals.

STEP 3: Calculate Clinical Efficiency Savings

Clinical efficiencies, based on estimated savings in patient days from the improvements in clinical utilization consistent with the HSRC methodology, are calculated using the revised levels of costs and clinical activity in the receiving hospital if program transfers are involved. Where benchmarks are applied, conservable days are based on three axes: CMG/DPG, age group, and peer group¹⁶¹⁷.

The following is the sequence of calculations to estimate savings associated with clinical efficiencies. Note that the calculation of clinical efficiencies is currently under development and will be incorporated into the methodology when finalized.

A. Alternate Level of Care (ALC)

ALC days are divided into surgical and medical categories associated with the original acute case designation. Different weighting factors based on the

¹⁶ Review groups are defined by the Ministry of Health as: Review Group 1: designated teaching facilities (excluding specialty), Review Group 2: designated community facilities, Review Group 3: designated small facilities.

¹⁷ The HSRC is contemplating adjusting the method from Peer to Review Groups - the changes are not reflected in the London figures;

results of the OCCP data analysis are then applied. In estimating the savings in this area, it is assumed that they will be realized at the hospital transferring the programs. Therefore, ALC savings are calculated at the lower of the expected or actual direct cost per weighted case of the sending facility.

i) estimated savings for medical ALC days be calculated as follows:

[conservable medical ALC days] x [medical caseload weighting factor of 0.10] x [direct cost per case]

ii) estimated savings for surgical ALC days be calculated as follows:

[conservable surgical ALC days] x [surgical weighting factor of 0.134] x [direct cost per case]

B. Other Factors Causing Hospitalization - Case Mix Group 851

The costs/savings associated with the inpatient case to related to CMG 851 are estimated as follows:

[number of cases related CMG 851] X [RIW] X [hospital average (direct) cost per case]

C. Diagnoses Not Normally Hospitalized - Case Mix Group 910

As is the case with CMG 851 cases associated with this CMG have a specific resource intensity weight (RIW) associated with them.

The following is the equation for estimating costs/savings associated with CMG 910 cases:

[number of cases] X [RIW] X [hospital average (direct) cost per case]

D. Day Surgery Conversion

The costs and savings attributed to same day surgery conversion are calculated by determining the variance in resource weights of the inpatient surgical CMG to that of the same day surgery Day Procedure Group (DPG). That is, the costs associated with the inpatient case to be converted are estimated using the CMG RIW and the hospital cost per weighted case. Then, the costs associated with the day surgery case that is generated are calculated using the DPG RIW and the hospital cost per weighted case. The

DPG cost estimate is subtracted from the CMG RIW cost estimate. The difference is the cost or saving associated with the conversion.

Inpatient Surgical Case ([average cost per weighted case] X [case weight/CMG]) less Day Surgical Case ([average cost per weighted case] X [case weight/DPG])

Note: This will be the methodology used upon finalization of the software programming necessary to make the calculations. In the interim, \$100 per conservable day, as stated in the original methodology, will be used to estimate savings.

E. May Not Require Hospitalization (MNRH)

Savings attributed to the MNRH surgical cases are calculated based upon the same-day surgery conversion methodology which is described in following sections.

The savings attributed to medical MNRH cases would be calculated based upon the weight of 0.533. The following is the recommended equation for estimating the costs of MNRH conservable days:

[Conservable days associated with MNRH CMGs (medical only)] X [0.533 weighting factor] X [Hospital Cost per Weighted Case]

F. Average Length of Stay (ALOS)

Starting with the estimation of potential conservable days associated with average length of stay, the methodology addresses costs associated with the conservable days.

Routine and Ancillary weights¹⁸ by Case Mix Group are used with the hospital's direct average cost per case to estimate the costs attributed to conservable days associated with improvements in length of stay.

The calculation is CMG-specific as follows:

¹⁸ Ontario Case Cost Project data were used for calculation of CMG-specific routine and ancillary weighting factors. Where data do not exist to support the creation of these weighting factors, the existing CIHI CMG specific Routine & Ancillary weights derived from the Maryland experience are used.

Conservable days x (Routine and Ancillary % of full cost x RIW per diem factor) x Hospital Specific Direct Case Cost

STEP 4: Determine Support Service Efficiencies

In order to determine the savings potential of consolidating support services, a number of options regarding the selection of these support services were considered. The HSRC settled on the following functions largely due to the size of the activity in budgetary terms; i.e., materials management, food services and laboratory services. Furthermore, there have been ample studies to support the assumptions and models employed by the HSRC in regard to these hospital activities. This is not to suggest that other cost centres are cannot be consolidated and savings realized by the hospitals.

The model developed to identify savings resulting from consolidation and improved efficiency in Food Services, Materials Management and Laboratories is based on a three dimensional matrix.

The three dimensions which influence the potential savings are:

1. Current operational performance;
2. Number of sites being consolidated; and
3. Critical mass or thresholds.

The three dimensions are indicated below.

	Estimated Saving Percentages/ Number of Sites to be Consolidated					
	2 - 3		4 - 6		7 - 9	
	Model A	Model B	Model A	Model B	Model A	Model B
Current Level Of Efficiency						
High						
Average						
Low						

A. Materials Management

Based on the implementation of best practices, the following table summarizes estimated potential savings within a region (where a region is defined as a group of hospitals within a geographic cluster).

Current levels of efficiency are addressed in the following section.

MATERIALS MANAGEMENT	Estimated Saving Percentages/ Number of Sites to be Consolidated		
	2 - 3	4 - 6	7 - 9
Current Level Of Efficiency			
High	23 %	28 %	33 %
Average	29 %	34 %	39 %
Low	35 %	40 %	45 %

Best Practices in Materials Management

The following list summarizes best practices which could be implemented in order to achieve savings through consolidation of materials management across a number of hospitals:

- ⇒ Product standardization and evaluation committees.
- ⇒ Coordinated contract/vendor negotiation.
- ⇒ Group purchasing.
- ⇒ Computerized inventory management.
- ⇒ Inventory control practices yielding an average of 20 inventory turns per year.
- ⇒ Centralized ordering and warehousing in one hospital site or off-site through a contracted service with just-in-time delivery to the consolidated hospitals.
- ⇒ Automated purchasing - electronic data interchange (EDI) for ordering and electronic funds transfer (EFT) for supplier payment.
- ⇒ Sterile processing - standardization of procedure trays and:
 - either, central sterile processing for common, low cost items.
 - or, use of a high percentage of disposable tray packs.

Current Levels of Efficiency in Materials Management - Definitions

Current Level Of Efficiency	Definition	Approximate Inventory Turns/Year
High	• Extensive use of buying group(s) or a prime vendor. • Purchasing decision involves users. • EDI/EFT • Ward stock top-up - top-up frequency minimized - large facilities use computerized inventory management and automated stock control systems (1). • Standardized products and procedure trays/case carts. • Some outsourcing of sterilization.	20 or more
Average	• Moderate use of buying group(s). • Purchasing decision - mix of buyers and users. • Manual ordering and accounts payable. • Ward stock top-up - daily top-up - manual stock control systems. • Limited standardization of products and procedure trays/case carts.	15

Current Level Of Efficiency	Definition	Approximate Inventory Turns/Year
Low	• Some use of buying group(s). • Purchasing decision by buyers. • Manual ordering and accounts payable. • Ward stock exchange carts - daily exchange - manual stock control systems. • No standardization of products and procedure trays/case carts.	10 or less

(1) e.g., bar coding, carousels, etc.

B. Laboratory Services

Based on the implementation of best practices, the following table summarizes estimated potential savings within a region (where a region is defined as a group of hospitals within a geographic cluster). Current levels of efficiency are addressed in a following section.

CLINICAL LABORATORY SERVICES	Estimated Saving Percentages/ Number of Sites to be Consolidated					
	2 - 3		4 - 6		7 - 9	
Current Level Of Efficiency	Model A	Model B	Model A	Model B	Model A	Model B
High	2%	5%	5%	10%	5%	15%
Average	5%	10%	10%	15%	10%	20%
Low	10%	15%	15%	20%	15%	25%

As noted in the table above the savings estimates range from 2% to 25% depending on the model selected and the characteristics of the hospitals involved. These figures relate only to hospital laboratories and do not include the community sector laboratories. If the latter were included it is possible to increase the savings potential. Other assumptions underlying the estimates are listed below as is the Models A and B identified in the above chart.

Best Practices For Laboratory Services

The following list summarizes best practices which could be implemented in order to achieve savings through consolidation of laboratory services across a number of hospitals.

Number Of Beds	Best Practices
Model A - Modified Central Laboratory Concept	
0- 79 beds	• Central laboratory that <u>processes most routine testing and all esoteric testing for the region.</u> Rapid response laboratories in all other facilities that meet the STAT testing needs of each institution. • Consolidated purchasing to maximize purchasing power. Networked information systems between central laboratory and rapid response laboratories. • Bar-coding technology for tracking/analyzing specimens. Centralized governance structure. • Linkages with academic health sciences centres. Note: Central facility(s) and hospitals should be located within a 1 hour drive of each other.

Model B - Central Laboratory Concept	
80 + beds	• Central laboratory that <u>testing for the region.</u> Rapid response laboratories in all other facilities that meet the STAT testing needs of each institution. • Consolidated purchasing to maximize purchasing power. Networked information systems between central laboratory and rapid response laboratories. • Bar-coding technology for tracking/analyzing specimens. • Centralized governance structure. • Linkages with academic health sciences centres. • Note: Central facility(s) and hospitals should be located within a 1 hour drive of each other.

Current Levels of Efficiency in Hospital Laboratory Services

Current Level of Efficiency	Definition
High	• Central laboratory concept virtually implemented • Core laboratories implemented • Purchasing power consolidated • Computerization with most sites linked • Centralized governance structure Effective utilization management program
Average	• Some cooperative arrangements • Some core laboratories • Some shared purchasing and use of buying groups • Computerization with some sites linked • Multiple governance structures
Low	• Autonomous laboratories • Limited or no core laboratories • No shared purchasing, use of some buying groups • Limited/no computerization; no computer linkages • Multiple governance structures • Limited or no utilization management program

C. Food Services

Based on the implementation of best practices, the following table summarizes estimated potential savings through consolidation of services within a region (where a region is defined as a group of hospitals within a geographic cluster). Current levels of efficiency are defined in further sections. Assumptions are listed below in a separate subsection.

There are a number of dimensions to food services savings:

- productivity improvements through technology;
- outsourcing part of production process; and
- reduction in overall meal days associated with reduced inpatient days.

Not all of the dimensions of food services are explored in this methodology. However, the method is consistent with numerous food service studies by hospitals, DHCs and other bodies commissioned over the past few years. The following chart outlines some benchmarks for savings from consolidation and efficiency improvement.

FOOD SERVICES	Estimated Saving Percentages/ Number of Sites to be Consolidated					
	2 - 3		4 - 6		7 - 9	
Current Level Of Efficiency	Model A	Model B	Model A	Model B	Model A	Model B
High	2%	9%	4%	11%	6%	14%
Average	4%	15%	7%	17%	10%	20%
Low	8%	22%	10%	24%	12%	26%

The table above notes that the savings can range between 2% of current expenses to 26% depending on the model, sites and current level of efficiency. Note that for chronic (i.e., complex continuing care)/rehabilitation facilities it is assumed that the complexity of cases, and therefore resource needs, is less than that for acute care facilities. Consequently, 75% of the savings rate attributed to acute care sites are applied to the chronic/rehab site.

Best Practices in Food Services

The following table summarizes best practices which could be implemented in order to achieve savings through consolidation of food services across a number of hospitals under two consolidation models.

Number Of Beds	Best Practices
Model A - Shared Management and Outsourcing	
0 - 79 beds	• Shared management, common non-selective menu (7 - 9 days), common nutritional protocols. • Outsourcing of 80% or more of food products, reducing the level of on-site production.
80 + beds	• Shared management, common 7-9 day non-selective menu, common nutritional protocols. • Outsourcing of 80% or more of food products, reducing the level of on-site production. • Cold plating and advanced meal delivery system (1).
Model B - Shared Management, Outsourcing and Meal Assembly	
All sizes	• Shared management, common non-selective menu, common nutritional protocols. • Outsourcing of 80% or more of food products, reducing the level of in- house production. • Centralized cold plating and warewashing (see assumptions). • Distribution of trayed and/or bulk meals from central facility(s) to consolidated hospitals. • Advanced meal delivery system (1).

1.1.1.1 Advanced meal delivery system: A cart system in which pre-plated meals are held chilled and re-thermalized automatically just prior to meal service time. Re-thermalization can take place centrally in the hospital's kitchen or decentrally in nutrition centres proximate to each patient unit. Hot beverages and ice cream are added to trays at the time of service.

Current Levels of Efficiency in Food Services

Current Level Of Efficiency	Definition	Approximately Productivity (Meal Days Per FTE)
High	• 80% to 100% outsourcing of food products. • Cold plating and use of an advanced meal delivery system for meal re-thermalization and delivery. • Efficient hospital layout in terms of meal distribution.	> 2,750
Average	• Mix of outsourced foods and on-site production. • Hot plating.	Between 2,250 and 2,750
Low	• On-site production. • Hot plating. • Inefficient hospital layout in terms of meal distribution.	< 2,250

Method of Assessing Savings Related to Materials Management, Food Services and Laboratories

In order to compare hospital performance with best practices consistent with the model, a survey is administered to hospitals under consideration. The results of this survey are tabulated and a score relative to the level of efficiency is assessed. The hospital and its particular situation is then plotted against each of the three dimensional grids to determine the level of savings achievable at best practices. Savings are determined at an aggregate level for the group of facilities and are prorated to the individual facilities based on their respective efficiency ratings. For example, an overall savings of 20% could be distributed as 10% savings to a high efficiency facility and 30% savings to a low efficiency facility (given a two-facility group with the same size budgets).

Since laboratory and food service expenses are part of the direct patient care costs, it is assumed that a by product of expense reductions due to clinical efficiencies will mean a reduction in the potential for savings in these areas. Therefore, the savings potential for Laboratory expenses and for Food Services expenses is then discounted for any reduction in direct costs that result from increased clinical efficiency.

STEP 5: Re-allocation of Other Expenses

Other savings may be identified through site closures and program reductions. These savings are community-specific and are based on net expenses as reported in the OCDM.

STEP 6: Calculate Site Closure Savings

Should a facility or site be subject to closure in various options, then net plant expenses are identified as savings. For plants that remain in various options these expenses are maintained.

STEP 7: Determine Administrative Efficiencies

Administrative expenses are those expenses which for the most part are fixed and do not vary directly with patient volumes. These non-variable costs tend to remain inside a set limit as a percentage of total hospital operating costs.

The categories included in Administrative Expenses were chosen to correspond to the overhead costs in the OCDM with a few exclusions (e.g. plant, materials management). The following are the primary functional centres that were included in the Administrative Expenses total.

Functional Centres					
Category	Account	Category	Account	Category	Account
General Admin	71110	Finance	71115	Human Resources	71120
Systems Support	71125	Communications	71130	Volunteer Services	71140
Housekeeping	71145	Laundry/Linen	71150	Bio-Med Engineer.	71175
Registration	71180	Patient Transport	71185	Health Records	71190
Admin/Supp Temp	71198	Pastoral Care	71199	Hospital Library	71810
Audiovisual	71820	Medical Illustration	71830	Inservice Education	71840
Admin & Supp - Ed	71850	Formal Ed.-Nsg	71860	D&T Formal Education	71870
Formal Ed.- Medical	71880				

The estimated savings from Administrative Efficiencies are based on benchmarking the Administrative expenses to comparable hospitals relative to net direct expenses (including plant and materials management). The benchmarks are based on the 10th percentile for each of the three review

groups¹⁹. A fourth review group was established for free-standing chronic/rehabilitation facilities. Specialty hospitals were not included in the creation of the benchmarks but administrative savings were estimated using the appropriate review group. The revised administrative expenses based on benchmark values are then subtracted from the initial administrative expenses (based on the above accounts), to determine administrative expense savings. The following table defines the benchmarks that were used for each of the review groups. Please note that the benchmarks are calculated and applied using these formulae:

New Total Operating Net Expense

= New Direct Net Expense (including plant and materials management)/(1-Benchmark Rate)

Administrative Expense Savings

= (New Total Operating Net Expense - New Direct Net Expense) - 1995/96 Net Admin. Expense

Review Group	10th Percentile - Benchmark	Minimum	Median	Maximum
Review Group 0 (Free- Standing)	17.14%	13.00%	20.13%	34.09%
Review Group 1	12.81%	11.97%	16.21%	18.53%
Review Group 2	13.75%	10.72%	16.56%	23.59%
Review Group 3	16.33%	13.83%	21.47%	31.74%

Step 8: Add back Selected Expenses

For institutions that are remaining open, Selected Expenses as identified in Step 1 are added back in total. For institutions where programs have been transferred or closed, the following expenses are transferred to the receiving facility, in proportion to the activities transferred.

Emergency physician remuneration (primary account 71930)

Depreciation - distributed & undistributed (secondary accounts 75000 & 95080)

Depreciation undistributed (primary account 8195080)

Other undistributed expenses - Operating (primary account 81990)

Net NEER (penalties/rebates)

Cash Discounts (secondary accounts 12090 & 12190)

¹⁹ Review groups are defined by the Ministry of Health as: Review Group 1: designated teaching facilities, Review Group 2: designated community facilities, Review Group 3: designated small facilities (as defined by the JPPC).

Step 9: Establish the Cost of the Reconfigured System

The total net expenses of the reconfigured system are then calculated by adding back the selected expenses identified in Step 1. This total reflects costs associated with all patient types in an acute-care facility.

Chronic (i.e., complex continuing care) and Palliative Care Costing Methodology

The methodology used to estimate the cost of a reconfigured chronic care (i.e., complex continuing care) and palliative care system and a reconfigured rehabilitation care system follows the methodology used in the calculation of costs for the acute care sector with a few differences. Net expenses and selected expenses are determined as outlined in Step 1 but only as related to chronic & respite, and palliative patient types.

The following assumptions are made in costing the program reductions/enhancements

- 1995/96 actual patient days are used for both chronic care (i.e., complex continuing care) and palliative patients;
- a 95% occupancy rate is used to derive the number of future days in the system based upon the number of beds sited at each institution;
- the cost of chronic care (i.e., complex continuing care) beds added to a facility is estimated at the lower of the median direct chronic cost per day or the actual direct chronic cost per day. This median is calculated separately for acute facilities and free-standing chronic care facilities;
- the cost of chronic care (i.e., complex continuing care) beds removed from a facility is estimated by multiplying the actual direct chronic cost per day by the number of days being reduced; and
- program reductions and closures are associated to chronic rather than palliative care, with the exception of the closure of a facility where *all* (i.e. chronic care (i.e., complex continuing care) and/or palliative) beds are removed from the system.

It is expected that current lower intensity chronic care (i.e., complex continuing care) patients will now be cared for within the long-term care system. Future patients who require chronic care (i.e., complex continuing care) will, on average, have a higher resource intensity than is currently exhibited. Consequently, a resource intensity adjustment of 17% was allocated to all facilities who continue to have chronic care (i.e., complex continuing care) patients.

There are no administrative efficiencies calculated on acute care hospitals, as they have already been calculated in the acute care methodology. However, administrative costs are adjusted to reflect program reductions/enhancements.

Administrative efficiencies are calculated for all free-standing facilities as described above in Step 7. As in the acute care methodology, for sites that close, plant and materials management net expenses are identified as savings. Selected expenses are added back for sites that remain open. The total net expenses of the reconfigured system are then calculated by adding back the selected expenses to the new direct and administrative expenses.

Rehabilitation Care Costing Methodology

Net and selected expenses are determined as outlined in Step 1 but only as related to rehabilitation care.

An adjustment is made for additional allied health expenses for all rehabilitation care beds. This additional expense is expected to cover the additional cost of allied health coverage on weekends.

The following assumptions are made in estimating the costs for the transfer of rehabilitation patients.

- regional beds have an occupancy rate of 90% and long-term & short-term beds have an occupancy rate of 95%;
- any program reductions are assumed to be on short-term beds at an occupancy rate of 95%;
- the cost for program reductions is estimated using the facility's actual rehabilitation direct cost per day, multiplied by the number of days to be reduced; and
- the cost for program enhancements is estimated at the lower of the median direct rehabilitation cost per day and the facility's actual direct rehabilitation cost per day. This median is calculated separately for acute facilities and free-standing chronic care facilities.

Administrative efficiencies are not found for acute care hospitals, as this has already been calculated in the acute care methodology. However, administrative costs are adjusted to reflect program transfers. Administrative efficiencies are calculated for all free-standing facilities as described above in Step 7. As in the acute care methodology, for sites that close, plant and materials management net expenses are identified as savings. Selected expenses are added back for sites that remain open. The total net expenses of the reconfigured system are then calculated by adding back the selected expenses to the adjusted expenses, program transfers, adjustments, and new administrative expenses.

CONCLUSION

This methodology for identification of costs and savings associated with restructuring options was developed to do the following:

- assist the HSRC in assessing the affordability criterion for various restructuring options;
- determine the extent of savings associated with:
 - clinical efficiencies
 - consolidation of support services
 - administrative overhead
 - costs of plant operations;
- use an approach consistent with industry practices and methodologies currently in place; and
- develop advice for the Minister of Health on the expenses and savings estimates associated with HSRC Directions and Recommendations.

The original methodology for costing of restructuring options as reported in the Thunder Bay, Sudbury, Lambton and Pembroke reports was modified from one developed by the Ministry of Health. While there were issues associated with the method, the basic approach was deemed acceptable to the hospital sector. The HSRC undertook to revise the methodology by examining relevant analysis and research into various categories of expenses and potential savings.

The HSRC had engaged the firm KPMG, and their associates, Healthcor, to assist the HSRC in its endeavors. Working with the Ontario Case Cost Project, the Fiscal Planning Working Group of the Joint Policy and Planning Committee, and its consultants, Hay Management, and the Ministry of Health, the HSRC identified areas of improvement to the methodology which it will implement in future review and revise estimates from past reports.

Concurrent with the revisions to the methodology, the HSRC developed, with the assistance of KPMG and Healthcor, a software modeling system based on the revised costing methodology. The system will facilitate the consistent application of the methodology.

The costing methodology results are summarized in each report of the HSRC as advice to the Ministry of Health and to the hospitals affected by the directions. The actual expenses and savings will require further development during the implementation of the directions by the hospitals in conjunction with the HSRC and the Ministry of Health. The HSRC strives to use the most accurate and consistent information possible in developing the estimates because it is aware that they can become targets and guideposts for implementation.

As always, the HSRC invites comment on any materials and approaches that it promulgates. This policy of openness will allow the HSRC to improve upon its

methods through the feedback from the industry and from the results of implementation as it proceeds in various communities.

If you have any comments regarding this report of any of the sections therein, the HSRC would appreciate your views in writing to the HSRC.

APPENDIX F: Capital Estimates

Assumptions:

1. New acute care construction, where there is a balance (50:50) between space allocated to high cost items (e.g., Emergency, NICU, Surgical Suite, Critical Care) and moderate/low cost items (e.g., Administrative, Materials Management, etc.) a blended rate of \$187 per square feet.
2. New acute care construction, where more than 50% of the space is high cost, a rate of \$210/sf will be applied.
3. New acute care construction, where more than 50% of the space is lower cost space, \$160/sf will be used.
4. New construction for mental health will be applied at a rate of \$140/sf (excluding medium secure forensic unit, which will be \$170/sf).
5. New construction for rehabilitation beds will be applied at a rate of \$160/sf.
6. New construction for complex continuing care beds will be applied at a rate of \$160/sf.
7. Renovation costs will be calculated as follows:

moderate level of renovations	moderate	\$100/sf
significant level of renovations	high	\$150/sf
very high level of technologically complex renovations	very high	\$180/sf
light renovations	light	\$50/sf

City: **Hamilton**Hospital: **Henderson**

Program	Beds	Area/Bed	Area Required
Beds			
Available	399		
Required	351		
Additional Needed	-48		
Target Area			
Acute	188	1,400	263,200 sf
Mental Health (A)	26	1,100	28,600 sf
Mental Health (LT+F)	-	1,100	- sf
Continuing Complex Care	117	1,000	117,000 sf
Rehabilitation	20	1,100	22,000 sf
Sub-Acute Care	-	1,000	- sf
Total	351		430,800 sf
Research	-		- sf
Academic Allocation	-		- sf
GFT	-		- sf
TOTAL			430,800 sf
Area Available			
Whole Hospital			641,916 sf
Total			641,916 sf
Additional Area Required			-211,116 sf

Focus of New Construction	Capacity	cgst	bgsf	cost/bgsf	Total New
Continuing Complex Care	117	49,725	62,902	160	\$10,064,340
Total		49,725	62,902		\$10,064,340

Focus of Renovation	Area (sf)	Renovation (m,h,vh,l)	Cost/sf	Total Reno.
Ambulatory care expnsn	6,500	m	\$100	\$650,000
Emergency/urgent care	4,500	m	\$100	\$450,000
Other displaced functions	25,000	l	\$50	\$1,250,000
Total				\$2,350,000

Total Construction Cost	\$12,414,340
Ancillary Costs @ 23.2%	\$2,880,127
Site Development Allowance	\$503,217
Furnishings & Equipment Allowance (out of contract)	\$2,482,868
TOTAL COST	\$18,280,552

Notes:

- 1) Whole Hospital area excludes the Hamilton Regional Cancer Centre.
- 2) Estimates include no allowance for correcting pre-existing deficiencies in areas not directly impacted by restructuring, eg ICU/CCU, acute care accommodation, surgical suite, diagnostic imaging.
- 3) Assumed that 40-Wing and 20-Wing would be vacated and demolished, eventually. Accordingly, available beds are approximately 65 less than previously indicated. Note that "Area Available" includes the 40- and 20-Wings. Actual area is therefore lower.
- 4) Emergency adapted for increased urgent care load.

City: **Hamilton**Hospital: **General**

Program	Beds	Area/Bed	Area Required
Beds			
Available	394		
Required	402		
Additional Needed	8		
Target Area			
Acute	321	1,400	449,400 sf
Mental Health	-	1,100	- sf
Continuing Complex Care	-	1,000	- sf
Rehabilitation	81	1,100	89,100 sf
Sub-Acute Care	-	1,000	- sf
Total	402		538,500 sf
Research	-		- sf
Academic Allocation	30,150		38,140 sf
GFT	-		- sf
TOTAL			576,640 sf
Area Available			
Whole Hospital			714,293 sf
Total			714,293 sf
Additional Area Required			-175,793 sf

Focus of New Construction	Capacity	cgsf	bgsf	cost/bgsf	Total New
Rehabilitation Beds	41	17,425	22,043	160	\$3,526,820
Expanded Rehab services		5,000	6,325	140	\$885,500
Other		-	-	-	-
Total		22,425	28,368		\$4,412,320

Focus of Renovation	Area (sf)	Renovation (m,h,vh,l)	Cost/sf	Total Reno.
Convert acute to rehab beds	40	allowance		\$200,000
Ambulatory Care expnsn	13,900	m	\$100	\$1,390,000
Total				\$1,590,000

Total Construction Cost	\$6,002,320
Ancillary Costs @ 23.2%	\$1,392,538
Site Development Allowance	\$220,616
Furnishings & Equipment Allowance (out of contract)	\$900,348
TOTAL COST	\$8,515,822

Notes:

- 1) Costs do not include for parking changes or land acquisition.

City: **Hamilton**Hospital: **MUMC**

Program	Beds	Area/Bed	Area Required
Beds			
Available	402		
Required	353		
Additional Needed	-49		
Target Area			
Acute	257	1,400	359,800 sf
Mental Health (A)	24	1,100	26,400 sf
Mental Health (P)	17	1,100	18,700 sf
Continuing Complex Care	35	1,000	35,000 sf
Rehabilitation	20	1,100	22,000 sf
Total	353		461,900 sf
Research	-		- sf
Academic Allocation	26,475		33,491 sf
GFT	-		- sf
TOTAL			495,391 sf
Area Available			
Whole Hospital			664,435 sf
Total			664,435 sf
Additional Area Required			-202,535 sf

Focus of New Construction	Capacity	cgsf	bgsf	cost/bgsf	Total New
		-	-		-
Total		-	-		-

Focus of Renovation	Area (sf)	Renovation (m,h,vh,l)	Cost/sf	Total Reno.
Paediatric expnsn	12,000	allowance		\$240,000
Paediatric MH	10,000	l	\$50	\$500,000
NICU expnsn, 14 places	8,400	vh	\$180	\$1,512,000
Surgical Suite, 3 OR expnsn	6,000	vh	\$180	\$1,080,000
Surgical Suite integration	1,500	h	\$150	\$225,000
Ambulatory expsn	4,900	m	\$100	\$490,000
Emergency expsn	1,900	h	\$150	\$285,000
Displaced functions, complx	7,900	h	\$150	\$1,185,000
Displaced functions, reglr	13,300	m	\$100	\$1,330,000
Total				\$5,517,000

Total Construction Cost	\$5,517,000
Ancillary Costs @ 23.2%	\$1,279,944
Site Development Allowance	
Furnishings & Equipment Allowance (out of contract)	\$2,892,500
TOTAL COST	\$9,689,444

Notes:

- 1) Total area of MUMC buildings 1,126,473 gross square feet, of which approximately 40% is believed to accommodate medical research and MU Medical School activity.

Program	Beds	Area/Bed	Area Required
Beds			
Available	571		
Required	619		
Additional Needed	48		
Target Area			
Acute	294	1,400	411,600 sf
Mental Health (A)	41	1,100	45,100 sf
Mental Health (LT+F)	142	1,100	156,200 sf
Continuing Complex Care	117	1,000	117,000 sf
Rehabilitation	25	1,100	27,500 sf
Total	619		757,400 sf
Research	-		- sf
Academic Allocation	46,425		58,728 sf
GFT	-		- sf
TOTAL			816,128 sf
Area Available			
Whole Hospital			771,790 sf
Total			771,790 sf
Additional Area Required			44,338 sf

Focus of New Construction	Capacity	cgsf	bgsf	cost/bgsf	Total New
Adult Acute Mental Health	42	17,850	22,580	140	\$3,161,235
Longer Term Mental Health	137	58,225	73,655	140	\$10,311,648
Forensic Mental Health	18	7,650	9,677	170	\$1,645,133
Other MH program space		14,000	17,710	140	\$2,479,400
Total		97,725	123,622		\$17,597,415

Focus of Renovation	Area (sf)	Renovation (m,h,vh,l)	Cost/sf	Total Reno.
Contng Cmplx Care, part	10,000	allowance		\$200,000
Contng Cmplx Care, part	11,500	allowance		\$230,000
Contng Cmplx Care, shell	7,500	m	\$100	\$750,000
Ambul'y Care expnsn	12,425	m	\$100	\$1,242,500
Displaced functions, MA-4	23,000	m	\$100	\$2,300,000
Surgical Suite, 2 OR expnsn	4,000	vh	\$180	\$720,000
Surgical Suite integration	1,000	h	\$150	\$150,000
Emergency Expansion	2,275	h	\$150	\$341,250
Total				\$5,933,750

Total Construction Cost	\$23,531,165
Ancillary Costs @ 23.2%	\$5,459,230
Site Development Allowance	\$1,319,806
Furnishings & Equipment Allowance (out of contract)	\$5,209,546
TOTAL COST	\$35,519,747

Notes:

- 1) Whole Hospital area includes the Fontbonne Building (108,700 gross square feet) but excludes the Community Health Centre (88,000 gross square feet).
- 2) Psychiatric accommodation assumed to be developed on close by, and linked to, the present site.
- 3) "Other MH program space" includes professional offices and ambulatory space. The latter is part of overall ambulatory increment.
- 4) Estimates do not include the cost of "enabling" developments, such as parking structures; or, land acquisition.
- 5) Rehabilitation beds to recovered acute bed space.
- 6) Continuing Complex Care consolidated to BD-4, (using vacated critical and acute care space and developed shell). Other CCC beds in converted acute care space.





HEALTH SERVICES RESTRUCTURING COMMISSION

Notices of Intention to Issue
Directions and Advice

Hamilton-Wentworth
Health Services
Restructuring
Report

November 1997

Health Services Restructuring Commission

IN THE MATTER OF the *Public Hospitals Act*
RSO 1990, c.P.40, as amended

AND IN THE MATTER OF Ontario Regulation 87/96
made under the *Public Hospitals Act*

AND IN THE MATTER OF The *Ministry of Health Act*
RSO 1990, c.M.26, as amended

AND IN THE MATTER OF Ontario Regulation 88/96
made under the *Ministry of Health Act*

NOTICE OF INTENTION TO ISSUE DIRECTIONS TO THE ST. JOSEPH'S HOSPITAL

TAKE NOTICE THAT the Health Services Restructuring Commission intends, not earlier than thirty-nine (39) days following the date of service of this Notice, to issue the following Directions to Board of Directors of the *St. Joseph's Hospital*.

THE HEALTH SERVICES RESTRUCTURING COMMISSION DIRECTS the Board of Directors of the *St. Joseph's Hospital* to:

1. In conjunction with the St. Peter's Hospital develop and submit by May 31, 1998 to the Minister of Health and the Health Services Restructuring Commission a plan to ensure the establishment of a governance structure that is representative of the communities served and will have regard to the demographic, cultural, religious, economic, geographic, linguistic, ethnic and social characteristics of the community.
2. Implement a plan by April 30, 2000 to operate 294 acute care beds, 41 acute mental health beds, 124 longer-term mental health beds, 18 forensic beds, 25 short-term local rehabilitation beds, 117 complex continuing care beds and emergency services at the St. Joseph site and operate an ambulatory care centre at the Stoney Creek site of the St. Joseph's Health Care Centre.
3. With the Hamilton Health Sciences Corporation, St. Peter's Hospital, and with the concurrence of the Minister of Health, Hamilton Psychiatric Hospital, McMaster University, Community Care Access Centre (CCAC) and the District Health Council (DHC) establish by April 30, 1998 and maintain until at least April 30, 2000 a joint committee which will have equal representation from the St. Joseph's Hospital, Hamilton Health Sciences Corporation, St. Peter's Hospital, and representation from Hamilton Psychiatric Hospital, McMaster University, CCAC and the District Health Council and be responsible for the implementation of the hospital restructuring plan

in Hamilton.

4. Appoint by April 30, 1998 the executive committee of the hospital's board of directors to the joint committee and delegate to the executive committee the powers to make decisions on behalf of the hospital that will implement the directions including:
 - the restructuring of hospital services, including the allocation and integration of services, and the continuum of care provided to patients
 - the implementation of plans that will address the impact of the hospital restructuring plan on hospital based teaching and research functions
5. In conjunction with the Hamilton Health Sciences Corporation develop and implement a plan to receive from the Hamilton Health Sciences Corporation, 50% of the pulmonary program currently located at the Henderson site by April 30, 2000. Submit a copy of the plan to both the Minister of Health and the Health Services Restructuring Commission.
6. In conjunction with the Hamilton Health Sciences Corporation develop and implement a plan to transfer to the Hamilton Health Sciences Corporation, all of the paediatric inpatient acute care program by April 30, 2000. Submit a copy of the plan to both the Minister of Health and the Health Services Restructuring Commission.
7. In conjunction with the St. Peter's Hospital, develop and begin implementation by June 30, 1998 of a plan to transfer the 50% of the complex continuing care program from the St. Peter's Hospital to the St. Joseph's Hospital by April 30, 2000. The plan will include the cessation of admissions of any patients by March 31, 2000. Submit a copy of the plan to both the Minister of Health and the Health Services Restructuring Commission.
8. In conjunction with St. Peter's Hospital and Hamilton Health Sciences Centre, determine the best location of ambulatory programs, such as "Easy Street".
9. In conjunction, with the concurrence of the Minister of Health, the Hamilton Psychiatric Hospital, develop and begin implementation by May 31, 1998 of a plan to
 - Transfer 124 longer term mental Health beds from the Hamilton Psychiatric Hospital and management and control of the outpatient programs operated by Hamilton Psychiatric in Hamilton Wentworth to the St. Joseph's Hospital by April 20, 2000;
10. In conjunction, with the concurrence of the Minister of Health, the Hamilton Psychiatric Hospital, develop and begin implementation by May 31, 1998 of a plan to transfer 18 forensic beds from the Hamilton Psychiatric Hospital to St. Joseph's Hospital.

11. With the concurrence of the Minister of Health, accept governance and management of Hamilton Psychiatric Hospital, on an interim basis pending the closure of the Hamilton Psychiatric Hospital by April 30, 2000.
12. Prepare and submit to the Minister of Health a plan that outlines a capital construction project for St. Joseph's Hospital which will consist of new construction for a mental health pavilion. Renovation will also be required for complex continuing care, surgical suite integration, ambulatory care and emergency service expansion. The total budget for the construction project should be set at a maximum of \$30.3 million. The total budget for equipment and furnishings should be set at a maximum of \$5.2 million.
13. In conjunction with the St. Joseph's Hospital and the McMaster University develop a plan by May 31, 1998 to designate St. Joseph's Hospital as the regional site for respirology services. This plan should include both clinical and academic components.
14. In conjunction with Hamilton Health Sciences Corporation, St. Peter's Hospital, and with the concurrence of the Minister of Health, the Hamilton Psychiatric Hospital and the District Health Council develop a plan for the provision of French language services in Hamilton. The plan should include a determination of which programs at each site will be designated under the French Language Services Act and a schedule of events required for the implementation of the plan.
15. In conjunction with the Hamilton Health Sciences Corporation, St. Peter's Hospital, and with the concurrence of the Minister of Health, Hamilton Psychiatric Hospital, Community Care Access Centre and the District Health Council, continue to develop planning for an Integrated Academic Health System. This plan should include partnerships with community and other providers, and include physician integration into the system. Submit a copy of the plan to the Minister of Health and the Health Services Restructuring Commission.
16. In conjunction with all Hamilton-Wentworth hospitals and the McMaster University develop an implementation plan which will address the relocation of research and education programs from the Hamilton Psychiatric Hospital, St. Peter's Hospital and the Chedoke site of the Hamilton Health Sciences Corporation. Submit a copy of the plan to the Minister of Health and the Health Services Restructuring Commission.
17. In conjunction with all Hamilton-Wentworth hospitals, and with the concurrence of the Minister of Health, Hamilton Psychiatric Hospital and representatives of affected employees and led by a convenor appointed by the Health Services Restructuring Commission, develop and begin implementation by May 31, 1998, of a human resource plan that will address the impact of the Health Services Restructuring Commission's directions on the hospitals' employees. The plan must include, at a minimum, the following components:

- The process for dealing with Human Resource issues common to all hospitals;
- A dispute resolution mechanism;
- The establishment of a jobs registry;
- The governance structure of the jobs registry and the participation of employee representatives in the governance structure;
- The mandatory participation of the hospitals in the jobs registry and any other jobs registry and process agreed to by the hospitals and employee representatives; and
- The funding plan for the registry.

The plan is to be submitted to both the Minister of Health and the Health Services Restructuring Commission.

18. In conjunction with the Hamilton Health Sciences Corporation, St. Peter's Hospital and Joseph Brant Memorial Hospital develop and begin implementation by June 30, 1998 of a plan to maximize the efficiency of the delivery of administrative services, support services and diagnostic services to the hospitals and other health care facilities in Hamilton-Wentworth. The plan must address alternative services delivery systems, including services that can be provided by the private sector. Submit a copy of the plan to the Minister of Health and the Health Services Restructuring Commission.
19. Led by a facilitator appointed by the Minister of Health, and in conjunction with the Hamilton Health Sciences Corporation and Joseph Brant Memorial Hospital develop and begin implementation by June 30, 1998 of a plan for the hospital laboratory and pathology service in the Hamilton hospitals and other health care facilities in Hamilton consistent with the Ministry of Health's Laboratory Reform Strategy. Submit a copy of the plan to the Minister of Health and the Health Services Restructuring Commission.
20. Submit to the Health Services Restructuring Commission and the Minister of Health quarterly progress reports on the status of implementation of the above directions, including a progress report on the implementation of the human resources adjustment plan, the administrative and support services plan and the laboratory services plan. The first report is to be submitted by July 31, 1998 for the quarter ending June 30, 1998.

The Health Services Restructuring Commission further directs the Board of Directors of the St. Joseph's Hospital to take all proceedings, corporate and otherwise, to implement such directions.

The Health Services Restructuring Commission's reasons for these Directions are included in the *Hamilton-Wentworth Health Services Restructuring Report* dated November, 1997 that has been prepared by the Health Services Restructuring Commission.

Accompanying this Notice are:

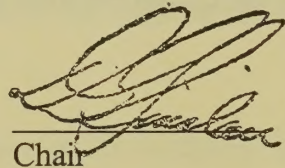
1. Copies of the Notice(s) of Intention to Issue Directions to the other hospitals in Hamilton-Wentworth;
2. Copies of the Notice(s) of Advice that the Health Services Restructuring Commission has provided to the Minister of Health of Ontario;
3. Guidelines issued by the Health Services Restructuring Commission for making representations to the Health Services Restructuring Commission; and
4. A copy of the *Hamilton-Wentworth Health Services Restructuring Report* dated November, 1997 prepared by the Health Services Restructuring Commission.

IF YOU WISH TO MAKE REPRESENTATIONS to the Health Services Restructuring Commission with relation to the intended directions, such representations must be received by the Commission

NOT LATER THAN THE CLOSE OF BUSINESS
AT 5:00 IN THE AFTERNOON
ON THE THIRTY-NINTH (39th) DAY

next following the date that this Notice is served, complying in form to the Guidelines of the Commission.

DATED at Toronto this 27th day of November, 1997.



Chair

Health Services Restructuring Commission
56 Wellesley Street West, 12th Floor
Toronto, Ontario
M5S 2S3

Tel: (416) 327-5919
FAX: (416) 327-5689

Date of Service of this Notice November 27, 1997

To: St. Joseph's Hospital
50 Charlton Avenue East
Hamilton, Ontario
L8N 4A8

Health Services Restructuring Commission

IN THE MATTER OF the *Public Hospitals Act*
RSO 1990, c.P.40, as amended

AND IN THE MATTER OF Ontario Regulation 87/96
made under the *Public Hospitals Act*

AND IN THE MATTER OF The *Ministry of Health Act*
RSO 1990, c.M.26, as amended

AND IN THE MATTER OF Ontario Regulation 88/96
made under the *Ministry of Health Act*

NOTICE OF ADVICE TO THE MINISTER OF HEALTH CONCERNING ST. JOSEPH'S HOSPITAL

1. The funding allocation to the hospital be adjusted to reflect the clinical and administrative efficiencies that will be achieved by the hospital and program transfers. Based on the latest available clinical and service data for 1995/96 the estimated adjustments in the costs of operation are:

St. Joseph's Hospital

Total St. Joseph's Hospital 1995/96 Net Expense	\$144,167,014	
St. Joseph's Hospital		\$144,167,014
Less Selected Expenses	-\$3,461,723	
Total Program Transfers	\$20,315,889	
Transfer of activity from St. Joseph's to Chedoke-McMaster		-\$6,286,997
Transfer of activity from Hamilton Civic to St. Joseph's		\$1,485,344
Mental Health Restructuring Allocation		\$25,241,182
Transfer of Materials Management		-\$123,639
Total Clinical Efficiencies	-\$10,155,009	
Alternative Level of Care		-\$3,425,438
Avoidable Admissions (CMG 851, 910, MNRH)		-\$54,742
Conversion to Day Surgery		-\$597,982
Length of Stay Reduction		-\$6,076,846
Total Support Service Efficiencies	-\$2,916,082	
Net Clinical Lab Efficiencies		-\$1,644,021
Net Food Services Efficiencies		-\$587,805
Discount for Clinical Eff.		\$158,994
Net Materials Mgmt Efficiencies		-\$843,250
Site Closures		\$0
Total Administrative Efficiencies	-\$2,628,915	
Add Selected Expenses	\$3,332,651	
Sub-Total	\$148,653,826	

Net Inpatient Rehabilitation Expense	\$0	
Less Selected Expenses		\$0
Program Reductions/Enhancements		\$2,195,276
Allied Health Expense Adjustment		\$157,629
Site Closure Expenses		\$0
Administrative Allocation		\$345,655
Add Selected Expenses		\$0
Revised Net Inpatient Rehabilitation Expense	\$2,698,559	
Change in Rehabilitation Expense	\$2,698,559	

Net Chronic Care & Palliative Expense	\$2,440,909	
Less Selected Expenses		-\$58,611
Program Reductions/Enhancements		\$5,225,067
Resource Intensity Adjustment		\$1,194,558
Site Closure Expenses		\$0
Transfer of Plant Expenses to Other Pt Activity		\$0
Administrative Allocation		\$943,079
Add Selected Expenses		\$58,611
Revised Net Complex Continuing Care Expense	\$9,803,614	
Change in Complex Continuing Care Expense	\$7,362,704	

Revised Total Operating Expense	\$158,715,090
Change in Operating Net Expense	\$14,548,076
Percent Change in Net Expenses	10.1%

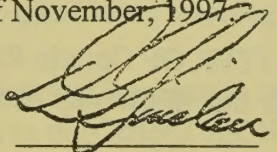
2. The estimated reductions in operating costs should be applied against any Ministry of Health reductions in operating funds in 1997/98 and 1998/99 for the St. Joseph's Hospital.
3. Consider adjustments to the amounts noted here to take into account non-Ministry of Health revenue and inflationary pressures that St. Joseph's Hospital may experience, and advise the Health Services Restructuring Commission of these considerations.
4. Respond to St. Joseph's Hospital by:
 - June 30, 1998 concerning the plan for governance and management changes
 - June 30, 1998, regarding the plan for transfer of longer term mental health and forensic programs from Hamilton Psychiatric Hospital.
5. The St. Joseph's Hospital be given approval to plan for a capital construction project which will consist of the renovations to the St. Joseph's Hospital. The total budget for the construction project, including construction, contingencies, fees, site development and equipment and furnishings should be set at a maximum of \$35.5 million.

The cost of the construction project and equipment and furnishings will be funded by the Ministry of Health and the hospital according to prevailing Ministry of Health policy.

Accompanying this Notice is:

1. Copies of the Notice(s) of the Intention to Issue Directions to the hospitals in Hamilton-Wentworth and;
2. A copy of the *Hamilton-Wentworth Health Services Restructuring Report* dated November, 1997 prepared by the Health Services Restructuring Commission.

DATED at Toronto this 27th day of November, 1997



Chair

Health Services Restructuring Commission
12th Floor
56 Wellesley Street West
Toronto, Ontario
M5S 2S3

Tel: (416) 327-5919

FAX: (416) 327-5689

To: The Honourable Elizabeth Witmer
Minister of Health
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Health Services Restructuring Commission

IN THE MATTER OF the *Public Hospitals Act*
RSO 1990, c.P.40, as amended

AND IN THE MATTER OF Ontario Regulation 87/96
made under the *Public Hospitals Act*

AND IN THE MATTER OF The *Ministry of Health Act*
RSO 1990, c.M.26, as amended

AND IN THE MATTER OF Ontario Regulation 88/96
made under the *Ministry of Health Act*

NOTICE OF INTENTION TO ISSUE DIRECTIONS TO THE HAMILTON HEALTH SCIENCES CORPORATION

TAKE NOTICE THAT the Health Services Restructuring Commission intends, not earlier than thirty-nine (39) days following the date of service of this Notice, to issue the following Directions to Board of Directors of the *Hamilton Health Sciences Corporation*.

THE HEALTH SERVICES RESTRUCTURING COMMISSION DIRECTS the Board of Directors of the *Hamilton Health Sciences Corporation* to:

1. In conjunction with St. Peter's Hospital submit by May 31, 1998 to the Minister of Health and the Health Services Restructuring Commission a plan to ensure a governance structure that is representative of the community served and that will have regard to the demographic, cultural, religious, economic, geographic, ethnic and social characteristics of the community.
2. Implement a plan by April 30, 2000 to operate 766 acute care beds, 50 acute mental health beds, 121 rehabilitation beds, 152 complex continuing care beds and emergency services at the McMaster University Medical Centre, the Hamilton General and Henderson sites. The plan should include consideration of an application to the Minister of Health to provide residential long term care services at the Chedoke site.
3. With the St. Joseph's Hospital, St. Peter's Hospital, and with the concurrence of the Minister of Health, Hamilton Psychiatric Hospital, McMaster University, Community Care Access Centre and the District Health Council establish by April 30, 1998 and until April 30, 2000 a joint committee which will have equal

representation from the St. Joseph's Hospital, Hamilton Health Sciences Corporation, St. Peter's Hospital and representation from Hamilton Psychiatric Hospital, McMaster University, Community Care Access Centre and the District Health Council and be responsible for the implementation of the hospital restructuring plan in Hamilton.

4. Appoint by April 30, 1998 the executive committee of the hospital's board of directors to the joint committee and delegate to the executive committee the powers to make decisions on behalf of the hospital that will implement the directions including:
 - the restructuring of hospital services, including the allocation and integration of services, and the continuum of care provided to patients
 - the implementation of plans that will address the impact of the hospital restructuring plan on hospital based teaching and research functions
5. Implement a plan to close the hospital's programs and services located at the Chedoke site and transfer them to the General and Henderson sites by April 30, 2000. Submit a copy of the plan to both the Minister of Health and the Health Services Restructuring Commission.
6. Submit by May 31, 1998 to the Minister of Health and the Health Services Restructuring Commission, the hospital board's plan for the decommissioning of the Chedoke site of the Hamilton Health Sciences Corporation.
7. In conjunction with the St. Joseph's Hospital develop and implement a plan to receive from the St. Joseph's Hospital all of the paediatric inpatient acute care program by April 30, 2000. Submit a copy of the plan to both the Minister of Health and the Health Services Restructuring Commission.
8. In conjunction with the St. Joseph's Hospital develop and implement a plan to transfer to the St. Joseph's Hospital, 50% of the pulmonary program currently located at the Henderson site by April 30, 2000. Submit a copy of the plan to both the Minister of Health and the Health Services Restructuring Commission.
9. In conjunction with the St. Peter's Hospital, develop and begin implementation by June 30, 1998 of a plan to transfer 50% of the complex continuing care program from the St. Peter's Hospital to the Henderson site of the Hamilton Health Sciences Corporation by April 30, 2000. The plan will include the cessation of admissions of any patients by March 31, 2000. Submit a copy of the plan to both the Minister of Health and the Health Services Restructuring Commission.
10. In conjunction with St. Peter's Hospital and St. Joseph's Hospital, determine the best location of ambulatory programs, such as "Easy Street".
11. Prepare and submit to the Minister of Health a plan that outlines a capital construction project for the General site which will consist of new construction for rehabilitation

services. Renovation will also be required in some areas. The total budget for the construction project should be set at a maximum of \$7.6 million. The total budget for equipment and furnishings should be set at a maximum of \$0.9 million.

12. Prepare and submit to the Minister of Health a plan that outlines a capital construction project for the Henderson site which will consist of new construction for a complex continuing care pavilion. Renovation will also be required to expand ambulatory care and emergency services. The total budget for the construction project should be set at a maximum of \$15.8 million. The total budget for equipment and furnishings should be set at a maximum of \$2.5 million.
13. Prepare and submit to the Minister of Health a plan that outlines a capital construction project for the McMaster site which will consist of renovations to ambulatory care, emergency services, NICU and surgical units.. The total budget for the construction project should be set at a maximum of \$6.8 million. The total budget for equipment and furnishings should be set at a maximum of \$2.9 million.
14. By January 31, 1998 take a leadership role in establishing an integrated approach to health services for children and adolescents in the Central West region of Ontario (i.e. Children's Health Network for Central West.). Representation on the network will be drawn from both hospitals and community agencies throughout Central West. The mandate of the Children's Healthcare Network will be to:
 - plan for levels of children's health care services that are appropriate to the needs of the population; and that address both hospital and community based services.
 - examine opportunities to reduce duplication in administrative overhead, research and direct service delivery;
 - develop appropriate care maps and clinical pathways that span hospital and community services
 - develop and implement appropriate information systems and technology, in cooperation with other providers, to facilitate a common information system for all providers
 - monitor the delivery of services.
 - serve as the paediatric component of academic teaching and research health system;
 - enhance linkages with other services for children and adolescents
15. Establish and develop the leadership role of Hamilton General site in the Rehabilitation Network of the Central West region. The responsibilities of the Network will be to:
 - Ensure coordination of and equitable access to rehabilitation services in Central West;
 - Establish linkages among the regional inpatient rehabilitation providers, acute care facilities in Brant County, Haldimand-Norfolk, Niagara,

Wellington, Hamilton-Wentworth and Halton; and community-based rehabilitation providers in Hamilton-Wentworth.

- Examine opportunities to reduce duplication in administrative overhead, research and direct service delivery;
- Establish siting of the 7 transition to independent living spaces and supportive housing for Hamilton-Wentworth and Brant County in conjunction with community-based providers;
- Determine the appropriate mechanisms for the delivery of in-home rehabilitation services in conjunction with the Community Care Access Centres (CCACs); and
- Develop a performance evaluation mechanism for the regional rehabilitation services system with respect to quality and access indicators.

16. In conjunction with Hamilton Health Sciences Corporation and the District Health Council develop a plan for the provision of French language services in Hamilton. The plan should include a determination of which programs at each site will be designated under the French Language Services Act and a schedule of events required for the implementation of the plan.
17. In conjunction with the St. Joseph's Hospital and the McMaster University develop a plan by May 31, 1998 to designate St. Joseph's Hospital as the regional site for respirology services. This plan should include both clinical and academic components.
18. In conjunction with all Hamilton-Wentworth hospitals and the McMaster University develop an implementation plan which will address the relocation of research and education programs from the Hamilton Psychiatric Hospital, St. Peter's Hospital and the Chedoke site of the Hamilton Health Sciences Corporation. Submit a copy of the plan to the Minister of Health and the Health Services Restructuring Commission.
19. In conjunction with the St. Joseph's Hospital, St. Peter's Hospital, and with the concurrence of the Minister of Health, Hamilton Psychiatric Hospital, Community Care Access Centre and the District Health Council, continue to develop planning for an Integrated Academic Health System. This plan should include partnerships with community and other providers, and include physician integration into the system. Submit a copy of the plan to the Minister of Health and the Health Services Restructuring Commission.
20. In conjunction with all Hamilton-Wentworth hospitals, and with the concurrence of the Minister of Health, Hamilton Psychiatric Hospital and representatives of affected employees and led by a convenor appointed by the Health Services Restructuring Commission, develop and begin implementation by May 31, 1998, of a human resource plan that will address the impact of the Health Services Restructuring Commission's directions on the hospitals' employees. The plan must include, at a minimum, the following components:

- The process for dealing with Human Resource issues common to all hospitals;
- A dispute resolution mechanism;
- The establishment of a jobs registry;
- The governance structure of the jobs registry and the participation of employee representatives in the governance structure;
- The mandatory participation of the hospitals in the jobs registry and any other jobs registry and process agreed to by the hospitals and employee representatives; and
- The funding plan for the registry.

The plan is to be submitted to both the Minister of Health and the Health Services Restructuring Commission.

21. In conjunction with the St. Joseph's Hospital, St. Peter's Hospital and Joseph Brant Memorial Hospital develop and begin implementation by June 30, 1998 of a plan to maximize the efficiency of the delivery of administrative services, support services and diagnostic services to the hospitals and other health care facilities in Hamilton-Wentworth. The plan must address alternative services delivery systems, including services that can be provided by the private sector. Submit a copy of the plan to the Minister of Health and the Health Services Restructuring Commission.
22. Led by a facilitator appointed by the Minister of Health, and in conjunction with the St. Joseph's Hospital develop and begin implementation by June 30, 1998 of a plan for the hospital laboratory and pathology service in the Hamilton hospitals and other health care facilities in Hamilton consistent with the Ministry of Health's Laboratory Reform Strategy. Submit a copy of the plan to the Minister of Health and the Health Services Restructuring Commission
23. Submit to the Health Services Restructuring Commission and the Minister of Health quarterly progress reports on the status of implementation of the above directions, including a progress report on the implementation of the human resources adjustment plan, the administrative and support services plan and the laboratory services plan. The first report is to be submitted by July 31, 1998 for the quarter ending June 30, 1998.

The Health Services Restructuring Commission further directs the Board of Directors of the Hamilton Health Sciences Corporation to take all proceedings, corporate and otherwise, to implement such directions.

The Health Services Restructuring Commission's reasons for these Directions are included in the *Hamilton-Wentworth Health Services Restructuring Report* dated November, 1997 that has been prepared by the Health Services Restructuring Commission.

Accompanying this Notice are:

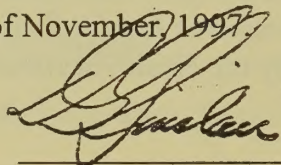
1. Copies of the Notice(s) of Intention to Issue Directions to the other hospitals in Hamilton-Wentworth;
2. Copies of the Notice(s) of Advice that the Health Services Restructuring Commission has provided to the Minister of Health of Ontario;
3. Guidelines issued by the Health Services Restructuring Commission for making representations to the Health Services Restructuring Commission; and
4. A copy of the *Hamilton-Wentworth Health Services Restructuring Report* dated November, 1997 prepared by the Health Services Restructuring Commission.

IF YOU WISH TO MAKE REPRESENTATIONS to the Health Services Restructuring Commission with relation to the intended directions, such representations must be received by the Commission

NOT LATER THAN THE CLOSE OF BUSINESS
AT 5:00 IN THE AFTERNOON
ON THE THIRTY-NINTH (39th) DAY

next following the date that this Notice is served, complying in form to the Guidelines of the Commission.

DATED at Toronto this 27th day of November, 1997.



Chair

Health Services Restructuring Commission
56 Wellesley Street West, 12th Floor
Toronto, Ontario
M5S 2S3

Tel: (416) 327-5919
FAX: (416) 327-5689

Date of Service of this Notice November 27, 1997

To: Hamilton Health Sciences Corporation
1200 Main Street West
Hamilton, Ontario
L8N 3Z5

Health Services Restructuring Commission

17

IN THE MATTER OF the *Public Hospitals Act*
RSO 1990, c.P.40, as amended

AND IN THE MATTER OF Ontario Regulation 87/96
made under the *Public Hospitals Act*

AND IN THE MATTER OF The *Ministry of Health Act*
RSO 1990, c.M.26, as amended

AND IN THE MATTER OF Ontario Regulation 88/96
made under the *Ministry of Health Act*

**NOTICE OF ADVICE TO THE MINISTER OF HEALTH
CONCERNING HAMILTON HEALTH SCIENCES CORPORATION**

1. The funding allocation to the hospital be adjusted to reflect the clinical and administrative efficiencies that will be achieved by the hospital and program transfers. Based on the latest available clinical and service data for 1995/96 the estimated adjustments in the costs of operation are:

Hamilton Health Sciences Corporation

Total Hamilton Health Sciences Corporation 1995/96 Net Expense	\$391,141,822	
Chedoke-McMaster Hospital Net Expense		\$166,973,591
Hamilton Civic Hospitals Net Expense		\$224,168,231
Less Selected Expenses	-\$13,961,012	
Total Program Transfers	\$4,507,220	
Transfer of activity from St. Joseph's to Chedoke-McMaster		\$6,144,194
Transfer of activity from Hamilton Civic to St. Joseph's		-\$1,717,863
Direct Savings Attributed to Transfers Between Chedoke-McMaster and Hamilton Civic		-\$1,135,168
Mental Health Restructuring Allocation		\$1,131,342
Transfer of Materials Management		\$84,715
Total Clinical Efficiencies	-\$24,341,237	
Alternative Level of Care		-\$6,752,493
Avoidable Admissions (CMG 851, 910, MNRH)		-\$265,953
Conversion to Day Surgery		-\$1,139,741
Length of Stay Reduction		-\$16,183,050
Total Support Service Efficiencies	-\$8,064,545	
Net Clinical Lab Efficiencies		-\$4,818,799
Net Food Services Efficiencies		-\$1,724,069
Discount for Clinical Eff.		\$466,110
Net Materials Mgmt Efficiencies		-\$1,987,788
Site Closures	-\$1,621,217	
Total Administrative Efficiencies	-\$13,970,246	
Add Selected Expenses	\$13,703,843	
Sub-Total	\$347,394,628	

Net Inpatient Rehabilitation Expense	\$17,729,863	
Less Selected Expenses		-\$689,74
Program Reductions/Enhancements		-\$3,137,64
Allied Health Expense Adjustment		\$742,34
Site Closure Expenses		\$
Administrative Allocation		-\$712,47
Add Selected Expenses		\$689,74
Revised Net Inpatient Rehabilitation Expense	\$14,622,091	
Change in Rehabilitation Expense	-\$3,107,772	

Net Chronic Care & Palliative Expense	\$16,038,249	
Less Selected Expenses		-\$626,36
Program Reductions/Enhancements		-\$1,659,59
Resource Intensity Adjustment		\$1,557,65
Site Closure Expenses		\$
Transfer of Plant Expenses to Other Pt Activity		\$
Administrative Allocation		-\$824,11
Add Selected Expenses		\$626,36
Revised Net Complex Continuing Care Expense	\$15,112,200	
Change in Complex Continuing Care Expense	-\$926,049	

Revised Total Operating Expense	\$343,360,807
Change in Operating Net Expense	-\$47,781,015
Percent Change in Net Expenses	-12.2%

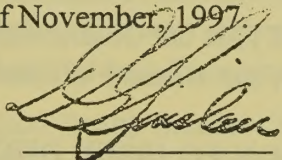
2. The estimated reductions in operating costs should be applied against any Ministry of Health reductions in operating funds in 1997/98 and 1998/99 for the Hamilton Health Sciences Corporation.
3. Consider adjustments to the amounts noted here to take into account non-Ministry of Health revenue and inflationary pressures that Hamilton Health Sciences Corporation may experience, and advise the Health Services Restructuring Commission of these considerations.
4. Consider an application by the Hamilton Health Sciences Centre to provide residential long term care services.
5. Respond to Hamilton Health Sciences Corporation by:
 - June 30, 1998 concerning the plan for governance and management changes
 - June 30, 1998 concerning the plan to decommission the Chedoke site
6. The Hamilton Health Sciences Corporation be given approval to plan for a capital construction project which will consist of the renovations to the Hamilton Health Sciences Corporation. The total budget for the construction project, including construction, contingencies, fees, site development and equipment and furnishings should be set at a maximum of \$36.5 million.

The cost of the construction project and equipment and furnishings will be funded by the Ministry of Health and the hospital according to prevailing Ministry of Health policy.

Accompanying this Advice is:

1. Copies of the Notice(s) of the Intention to Issue Directions to the hospitals in Hamilton-Wentworth and;
2. A copy of the *Hamilton-Wentworth Health Services Restructuring Report* dated November, 1997 prepared by the Health Services Restructuring Commission.

DATED at Toronto this 27th day of November, 1997.


Chair

Health Services Restructuring Commission
12th Floor
56 Wellesley Street West
Toronto, Ontario
M5S 2S3

Tel: (416) 327-5919
FAX: (416) 327-5689

To: The Honourable Elizabeth Witmer
Minister of Health
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Health Services Restructuring Commission

IN THE MATTER OF the *Public Hospitals Act*
R.S.O. 1990, c.P.40, as amended

AND IN THE MATTER OF Ontario Regulation 87/96
made under the *Public Hospitals Act*

AND IN THE MATTER OF The *Ministry of Health Act*
R.S.O. 1990, c.M.26, as amended

AND IN THE MATTER OF Ontario Regulation 88/96
made under the *Ministry of Health Act*

NOTICE OF INTENTION TO ISSUE DIRECTIONS TO THE ST. PETER'S HOSPITAL

TAKE NOTICE THAT the Health Services Restructuring Commission intends, not earlier than thirty-nine (39) days following the date of service of this Notice, to issue the following Directions to Board of Directors of the *St. Peter's Hospital*.

THE HEALTH SERVICES RESTRUCTURING COMMISSION DIRECTS the Board of Directors of the *St. Peter's Hospital* to:

1. Cease to operate as a public hospital effective April 30, 2000. St. Peter's Hospital should consider making an application to the Minister of Health to provide residential long term care services on the St. Peter's site.
2. In conjunction with St. Joseph's Hospital submit by May 31, 1998 to the Minister of Health and the Health Services Restructuring Commission a plan to ensure a governance structure for St. Joseph's Hospital is representative of the community served and that will have regard to the demographic, cultural, religious, economic, geographic, ethnic and social characteristics of the community.
3. In conjunction with the Hamilton Health Sciences Corporation submit by May 31, 1998 to the Minister of Health a plan to ensure a governance structure for the Hamilton Health Sciences Corporation is representative of the community served and that will have regard to the demographic, cultural, religious, economic, geographic, ethnic and social characteristics of the community.
4. With the St. Joseph's Hospital, Hamilton Health Sciences Corporation, and with the concurrence of the Minister of Health, Hamilton Psychiatric Hospital, McMaster University, Community Care Access Centre and the District Health Council establish

by April 30, 1998 and until April 30, 2000 a joint committee which will have equal representation from the St. Joseph's Hospital, Hamilton Health Sciences Corporation, St. Peter's Hospital and representation from Hamilton Psychiatric Hospital, McMaster University, the Community Care Access Centre and the District Health Council and be responsible for the implementation of the hospital restructuring plan in Hamilton.

5. Appoint by April 30, 1998 the executive committee of the hospital's board of directors to the joint committee and delegate to the executive committee the powers to make decisions on behalf of the hospital that will implement the directions including:
 - the restructuring of hospital services, including the allocation and integration of services, and the continuum of care provided to patients
 - the implementation of plans that will address the impact of the hospital restructuring plan on hospital based teaching and research functions
6. In conjunction with the Hamilton Health Sciences Corporation, develop and begin implementation by June 30, 1998 of a plan to transfer 50% of the complex continuing care program from the St. Peter's Hospital to the Henderson site of the Hamilton Health Sciences Corporation by April 30, 2000. The plan will include the cessation of admissions of any patients by March 31, 2000. Submit a copy of the plan to both the Minister of Health and the Health Services Restructuring Commission.
7. In conjunction with the St. Joseph's Hospital, develop and begin implementation by June 30, 1998 of a plan to transfer 50% of the complex continuing care program from the St. Peter's Hospital to the St. Joseph's Hospital by April 30, 2000. The plan will include the cessation of admissions of any patients by March 31, 2000. Submit a copy of the plan to both the Minister of Health and the Health Services Restructuring Commission.
8. In conjunction with Hamilton Health Sciences Centre and St. Joseph's Hospital, determine the best location of ambulatory programs, such as "Easy Street".
9. By May 31, 1998 pass a resolution that would prohibit the transfer of any hospital funds and assets to any related hospital foundation or any other person without a further direction from the Health Services Restructuring Commission.
10. Submit by May 31, 1998 to the Minister of Health and the Commission the hospital board's recommendations for the disposal of the hospital's land, buildings and assets and their distribution, including appropriate compensation to the extent that any assets to be transferred have not been paid for directly or indirectly by funds received from the Crown.
11. In conjunction with the St. Joseph's Hospital, Hamilton Health Sciences Corporation, and with the concurrence of the Minister of Health, Hamilton Psychiatric Hospital, Community Care Access Centre and the District Health Council, continue to develop planning for an Integrated Academic Health System. This plan should include

partnerships with community and other providers, and include physician integration into the system. Submit a copy of the plan to the Minister of Health and the Health Services Restructuring Commission.

12. In conjunction with all Hamilton-Wentworth hospitals and the McMaster University develop an implementation plan which will address the relocation of research and education programs from the Hamilton Psychiatric Hospital, St. Peter's Hospital and the Chedoke site of the Hamilton Health Sciences Corporation. Submit a copy of the plan to the Minister of Health and the Health Services Restructuring Commission.
13. In conjunction with all Hamilton-Wentworth hospitals, and with the concurrence of the Minister of Health, Hamilton Psychiatric Hospital and representatives of affected employees and led by a convenor appointed by the Health Services Restructuring Commission, develop and begin implementation by May 31, 1998, of a human resource plan that will address the impact of the Health Services Restructuring Commission's directions on the hospitals' employees. The plan must include, at a minimum, the following components:
 - The process for dealing with Human Resource issues common to all hospitals;
 - A dispute resolution mechanism;
 - The establishment of a jobs registry;
 - The governance structure of the jobs registry and the participation of employee representatives in the governance structure;
 - The mandatory participation of the hospitals in the jobs registry and any other jobs registry and process agreed to by the hospitals and employee representatives; and
 - The funding plan for the registry.

The plan is to be submitted to both the Minister of Health and the Health Services Restructuring Commission.

14. In conjunction with all Hamilton-Wentworth hospitals develop and begin implementation by June 30, 1998 of a plan to maximize the efficiency of the delivery of administrative services, support services and diagnostic services of the hospitals and other health care facilities in Hamilton-Wentworth. The plan must address alternative services delivery systems, including services that can be provided by the private sector. Submit a copy to both the Minister of Health and the Health Services Restructuring Commission.
15. Led by a facilitator appointed by the Minister of Health, and in conjunction with all Hamilton-Wentworth hospitals develop and begin implementation by June 30, 1998 of a plan for the hospital laboratory and pathology service in the Hamilton-Wentworth

hospitals that is consistent with the directions of the Ministry of Health's Laboratory Reform Strategy. Submit a copy to both the Minister of Health and the Health Services Restructuring Commission.

16. Submit to the Health Services Restructuring Commission quarterly progress reports on the status of the implementation of the above directions, including a progress report on the implementation of the human resources adjustment plan, the program transfer plan, the administrative and support services plan and the laboratory services plan. The first report is to be received at the latest by July 31, 1998 for the period ending June 30, 1998.

The Health Services Restructuring Commission further directs the Board of Directors of the St. Peter's Hospital to take all proceedings, corporate and otherwise, to implement such directions.

The Health Services Restructuring Commission's reasons for these Directions are included in the *Hamilton-Wentworth Health Services Restructuring Report* dated November, 1997 that has been prepared by the Health Services Restructuring Commission.

Accompanying this Notice are:

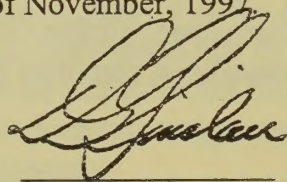
1. Copies of the Notice(s) of Intention to Issue Directions to the other hospitals in Hamilton-Wentworth;
2. Copies of the Notice(s) of Advice that the Health Services Restructuring Commission has provided to the Minister of Health of Ontario;
3. Guidelines issued by the Health Services Restructuring Commission for making representations to the Health Services Restructuring Commission; and
4. A copy of the *Hamilton-Wentworth Health Services Restructuring Report* dated November, 1997 prepared by the Health Services Restructuring Commission.

IF YOU WISH TO MAKE REPRESENTATIONS to the Health Services Restructuring Commission with relation to the intended directions, such representations must be received by the Commission

NOT LATER THAN THE CLOSE OF BUSINESS
AT 5:00 IN THE AFTERNOON
ON THE THIRTY-NINTH (39th) DAY

next following the date that this Notice is served, complying in form to the Guidelines of the Commission.

DATED at Toronto this 27th day of November, 1997.



Chair

Health Services Restructuring Commission
56 Wellesley Street West, 12th Floor
Toronto, Ontario
M5S 2S3

Tel: (416) 327-5919
FAX: (416) 327-5689

Date of Service of this Notice November 27, 1997

To: St. Peter's Hospital
88 Maplewood Avenue
Hamilton, Ontario
L8M 1W9

Health Services Restructuring Commission

IN THE MATTER OF the *Public Hospitals Act*
R.S.O. 1990, c.P.40, as amended

AND IN THE MATTER OF Ontario Regulation 87/96
made under the *Public Hospitals Act*

AND IN THE MATTER OF The *Ministry of Health Act*
R.S.O. 1990, c.M.26, as amended

AND IN THE MATTER OF Ontario Regulation 88/96
made under the *Ministry of Health Act*

NOTICE OF ADVICE TO THE MINISTER OF HEALTH CONCERNING THE ST. PETER'S HOSPITAL

1. The funding allocation to the hospital be adjusted to reflect the clinical and administrative efficiencies that will be achieved by the hospital and program transfers. Based on the latest available clinical and service data for 1995/96 the estimated adjustments in the costs of operation are:

St. Peter's Hospital

Total St. Peter's Hospital 1995/96 Net Expense	\$24,543,033	
Less Net Outpatient Operating Expense		-\$1,497,114
Net Chronic Care & Palliative Expense	\$23,045,919	
Less Selected Expenses		-\$653,770
Program Reductions/Enhancements		-\$15,705,784
Resource Intensity Adjustment		\$0
Site Closure Expenses		-\$1,475,936
Transfer of Plant Expenses to Other Pt Activity		\$0
Administrative Allocation		-\$5,210,430
Add Selected Expenses		\$0
Revised Net Complex Continuing Care Expense		\$0
Change in Complex Continuing Care Expense	-\$23,045,919	
Revised Total Operating Expense		\$0
Change in Operating Net Expense	-\$24,543,033	
Percent Change in Net Expenses		-100.0%

2. Effective April 30, 2000 funding to the St. Peter's Hospital should be transferred to the Hamilton Health Sciences Corporation and St. Joseph's Hospital.

3. The funding allocation for programs to be transferred between hospitals has been calculated based on the following principles:

the funding reduction to the hospital that is transferring the program should be based on the actual direct costs for the program

the funding increase to the hospital receiving the program should be at the lower of the actual or expected direct cost for such programs adjusted for the hospital's case load

4. Consider an application by the St. Peter's Hospital to provide residential long term care services.

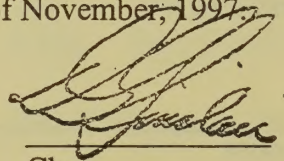
5. Respond to the St. Peter's Hospital by:

June 30, 1998 concerning the plan for disposition of assets.

Accompanying this Advice is:

1. Copies of the Notice(s) of the Intention to Issue Directions to the hospitals in Hamilton-Wentworth and;
2. A copy of the *Hamilton-Wentworth Health Services Restructuring Report* dated November, 1997 prepared by the Health Services Restructuring Commission.

DATED at Toronto this 27th day of November, 1997.



Chair

Health Services Restructuring Commission
12th Floor
56 Wellesley Street West
Toronto, Ontario
M5S 2S3

Tel: (416) 327-5919
FAX: (416) 327-5689

To: The Honourable Elizabeth Witmer
Minister of Health
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Health Services Restructuring Commission

IN THE MATTER OF the *Public Hospitals Act*
R.S.O. 1990, c.P.40, as amended

AND IN THE MATTER OF Ontario Regulation 87/96
made under the *Public Hospitals Act*

AND IN THE MATTER OF The *Ministry of Health Act*
R.S.O. 1990, c.M.26, as amended

AND IN THE MATTER OF Ontario Regulation 88/96
made under the *Ministry of Health Act*

NOTICE OF ADVICE TO THE MINISTER OF HEALTH

TAKE NOTICE THAT the Health Services Restructuring Commission intends, not earlier than thirty-nine (39) days following the date of service of this Notice, *advise* the Minister of Health *to undertake the following*:

THE HEALTH SERVICES RESTRUCTURING COMMISSION advises the Minister of Health to:

1. Cease the operation of mental health services at the Hamilton Psychiatric Hospital by April 30, 2000.
2. Pending the closure of the Hamilton Psychiatric Hospital, and the transfer of its programs, transfer the governance and management of mental health services at the Hamilton Psychiatric Hospital to the St. Joseph's Hospital.
3. With the Hamilton Health Sciences Corporation, St. Peter's Hospital, McMaster University, Community Care Access Centre (CCAC) and the District Health Council establish by April 30, 1998 and until April 30, 2000 a joint committee which will have equal representation from the St. Joseph's Hospital, Hamilton Health Sciences Corporation, St. Peter's Hospital, and representation from Hamilton Psychiatric Hospital, McMaster University, CCAC and the District Health Council and be responsible for the implementation of the hospital restructuring plan in Hamilton.
4. Appoint by April 30, 1998 a representative(s) of the hospital to the joint committee and delegate to the representative(s) the powers to make decisions on behalf of the hospital that will implement the directions including:
 - the restructuring of hospital services, including the allocation and integration of services, and the continuum of care provided to patients
 - the implementation of plans that will address the impact of the hospital restructuring plan on hospital based teaching and research functions

5. In conjunction with the St. Joseph's Hospital develop and begin implementation by May 31, 1998 of a plan to
 - Transfer 124 longer term mental health beds and 18 forensic beds from the Hamilton Psychiatric Hospital to St. Joseph's Hospital.

Submit a copy of the plan to the Minister of Health and the Health Services Restructuring Commission.

6. In conjunction with all Hamilton-Wentworth hospitals, and representatives of affected employees and led by a convenor appointed by the Health Services Restructuring Commission, develop and begin implementation by May 31, 1998, of a human resource plan that will address the impact of the Health Services Restructuring Commission's directions on the hospitals' employees. The plan must include, at a minimum, the following components:
 - The process for dealing with Human Resource issues common to all hospitals;
 - A dispute resolution mechanism;
 - The establishment of a jobs registry;
 - The governance structure of the jobs registry and the participation of employee representatives in the governance structure;
 - The mandatory participation of the hospitals in the jobs registry and any other jobs registry and process agreed to by the hospitals and employee representatives; and
 - The funding plan for the registry.

The plan is to be submitted to both the Minister of Health and the Health Services Restructuring Commission.

7. In conjunction with the St. Joseph's Hospital, Hamilton Health Sciences Corporation, the St. Peter's Hospital, Community Care Access Centre and the District Health Council, continue to develop planning for an Integrated Academic Health System. This plan should include partnerships with community and other providers, and include physician integration into the system. Submit a copy of the plan to the Minister of Health and the Health Services Restructuring Commission.
8. In conjunction with all Hamilton-Wentworth hospitals and the McMaster University develop an implementation plan which will address the relocation of research and education programs from the Hamilton Psychiatric Hospital, St. Peter's Hospital and the Chedoke site of the Hamilton Health Sciences Corporation. Submit a copy of the plan to the Minister of Health and the Health Services Restructuring Commission.

9. Submit to the Health Services Restructuring Commission quarterly progress reports on the status of the implementation of the above directions, including a progress report on the implementation of the human resources adjustment plan, and the program transfer plan. The first report is to be received at the latest by July 31, 1998 for the period ending June 30, 1998.

The Health Services Restructuring Commission's reasons for this Advice are included in the *Hamilton-Wentworth Health Services Restructuring Report* dated November 1997 that has been prepared by the Health Services Restructuring Commission.

Accompanying this Advice are:

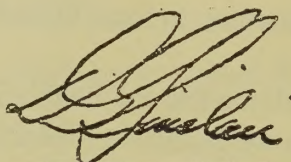
1. Copies of the Notice(s) of Intention to Issue Directions to the other hospitals in Hamilton-Wentworth;
2. Copies of the Notice(s) of Advice that the Health Services Restructuring Commission has provided to the Minister of Health of Ontario;
3. Guidelines issued by the Health Services Restructuring Commission for making representations to the Health Services Restructuring Commission; and
4. A copy of the *Hamilton-Wentworth Health Services Restructuring Report* dated November, 1997 prepared by the Health Services Restructuring Commission.

IF YOU WISH TO MAKE REPRESENTATIONS to the Health Services Restructuring Commission with relation to the intended directions, such representations must be received by the Commission

NOT LATER THAN THE CLOSE OF BUSINESS
AT 5:00 IN THE AFTERNOON
ON THE THIRTY-NINTH (39th) DAY

next following the date that this Advice is served, complying in form to the Guidelines of the Commission.

DATED at Toronto this 27th day of November, 1997.



Chair

Health Services Restructuring Commission
56 Wellesley Street West, 12th Floor
Toronto, Ontario
M5S 2S3

Tel: (416) 327-5919
FAX: (416) 327-5689

Date of Service of this Notice November 27, 1997

To: The Honourable Elizabeth Witmer
Minister of Health
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Health Services Restructuring Commission

IN THE MATTER OF the *Public Hospitals Act*
R.S.O. 1990, c.P.40, as amended

AND IN THE MATTER OF Ontario Regulation 87/96
made under the *Public Hospitals Act*

AND IN THE MATTER OF The *Ministry of Health Act*
R.S.O. 1990, c.M.26, as amended

AND IN THE MATTER OF Ontario Regulation 88/96
made under the *Ministry of Health Act*

NOTICE OF ADVICE TO THE MINISTER OF HEALTH CONCERNING THE HAMILTON PSYCHIATRIC HOSPITAL

1. The funding allocation to the hospital be adjusted to reflect the program transfers.
Based on the latest available data for 1995/96 the estimated adjustments in the costs of operation are:

Hamilton Psychiatric Hospital

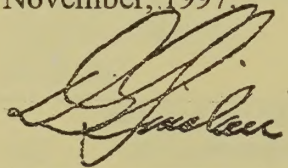
Total Hamilton Psychiatric Hospital 1995/96 Net Expense	\$44,298,391	
Hamilton Psychiatric Hospital Net Expense		\$44,298,391
Less Selected Expenses	\$0	
Total Program Transfers	-\$28,189,466	
Mental Health Restructuring Allocation		-\$27,784,594
Transfer of Materials Management		-\$404,872
Total Clinical Efficiencies	\$0	
Alternative Level of Care		\$0
Avoidable Admissions (CMG 851, 910, MNRH)		\$0
Conversion to Day Surgery		\$0
Length of Stay Reduction		\$0
Total Support Service Efficiencies	\$0	
Net Clinical Lab Efficiencies		\$0
Net Food Services Efficiencies		\$0
Discount for Clinical Eff.		\$0
Net Materials Mgmt Efficiencies		\$0
Site Closures	-\$2,285,568	
Total Administrative Efficiencies	-\$13,823,357	
Add Selected Expenses	\$0	
Change in Net Expense	\$0	
Revised Total Operating Expense		\$0
Change in Operating Net Expense	-\$44,298,391	
Percent Change in Net Expenses		-100.0%

- 2 Effective April 30, 2000 all funding to the Hamilton Psychiatric Hospital should cease.
- 3 The funding allocation for programs to be transferred between hospitals has been calculated based on the following principles:
 - the funding reduction to the hospital that is transferring the program should be based on the actual direct costs for the program
 - the funding increase to the hospital receiving the program should be at the lower of the actual or expected direct cost for such programs adjusted for the hospital's case load

Accompanying this Advice are:

1. Copies of the Notice(s) of the Intention to Issue Directions to the hospitals in Hamilton-Wentworth and;
2. A copy of the *Hamilton-Wentworth Health Services Restructuring Report* dated November, 1997 prepared by the Health Services Restructuring Commission.

DATED at Toronto this 27th day of November, 1997.



Chair

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12th Floor
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AND IN THE MATTER OF The *Ministry of Health Act*
RSO 1990, c.M.26, as amended

AND IN THE MATTER OF Ontario Regulation 88/96
made under the *Ministry of Health Act*

NOTICE OF ADVICE TO THE MINISTER OF HEALTH CONCERNING REINVESTMENT AND OTHER ISSUES IN THE HAMILTON- WENTWORTH HEALTH CARE SYSTEM

Reinvestment and Investment in Capital Infrastructure

1. The St. Joseph's Hospital should be given approval to plan for a capital construction project including: consolidation of all acute and longer-term mental health, up to a maximum of \$35.5 million total capital costs including ancillary, site development, and new furnishings and equipment. The cost of the construction project and equipment and furnishings should be funded by the Ministry of Health and the hospital according to prevailing Ministry of Health policy.
2. The Hamilton Health Sciences Corporation should be given approval to plan for a capital construction project including: consolidation of all paediatrics and an additional 9 NICU, up to a maximum of \$36.5 million total capital costs including ancillary, site development, and new furnishings and equipment. The cost of the construction project and equipment and furnishings should be funded by the Ministry of Health and the hospital according to prevailing Ministry of Health policy.

3. The Ministry of Health reinvest the following operating funds to mitigate the effects of restructuring of hospital services and address the current gaps in service:

<i>Estimates of Reinvestment Requirements</i>	
<i>Category</i>	<i>Amount</i>
Acute care- Level III neonatal ICU beds	\$2.8 Million
Home Care	\$ 3.1 Million
Long-Term Care	\$21 Million
Sub-Acute Care	\$ 7.1Million
Mental Health	\$1.4 Million
Rehabilitation	\$0.3 Million
Information Technology System	tba
Total	\$35.7.Million

4. The Health Services Restructuring Commission will give further consideration to what adjustments may be required to support enhancement of information services.

Laboratory Services

5. Appoint by April 30th , 1998, a facilitator to assist the St. Joseph's Hospital, the Hamilton Health Sciences Corporation and St. Peter's Hospital to develop and begin implementing by June 30, 1998, a plan for the hospital laboratory and pathology services in Hamilton-Wentworth that is consistent with the directions of the Ministry of Health's Laboratory Reform Strategy.

Mental Health

6. Complete the Central West Mental Health plan with respect to the issues identified in the Hamilton-Wentworth Health Services Restructuring Report (November 1997) i.e. role of Homewood Health Centre.

Integrated Academic Health System

7. The Hamilton-Wentworth County District Health Council and the Community Care Access Centre be requested to participate on the planning and implementation process for developing an integrated academic system of delivery of health care services, including the feasibility of establishing an integrated governance of health services.

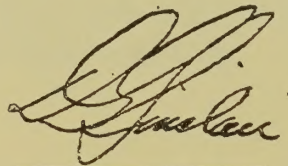
The goals of the integrated health system should include:

- a common information system
- community health goals, objectives and policies
- advocacy for fair funding
- negotiated partnership agreements among providers
- an allocation of responsibilities and funds for programs based on
- collaborative approach
- an evaluation of performance of the system against agreed goals.
- openness communication, and participation by all stakeholders

Accompanying this Notice are:

1. Copies of the Notice(s) of Intention to Issue Directions to the other hospitals in Hamilton-Wentworth;
2. Copies of the recommendations that the Health Services Restructuring Commission has provided to the Minister of Health of Ontario;
3. Guidelines issued by the Health Services Restructuring Commission for making representations to the Health Services Restructuring Commission; and
4. A copy of the *Hamilton-Wentworth Health Services Restructuring Report* prepared by the Health Services Restructuring Commission.
5. A copy of the Advice to the Minister of Health concerning Mental Health Services in the Central West region of Ontario.

DATED at Toronto this 27th day of November, 1997.



Chair
Health Services Restructuring Commission
12th Floor
56 Wellesley Street West
Toronto, Ontario
M5S 2S3

Tel: (416) 327-5919
FAX: (416) 327-5689

To: The Honourable Elizabeth Witmer
Minister of Health
10th Floor, Hepburn Block
80 Grosvenor Street
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HEALTH SERVICES RESTRUCTURING COMMISSION

GUIDELINES RESPECTING REPRESENTATIONS THAT MAY BE MADE TO THE COMMISSION

These Guidelines are issued by the Health Services Restructuring Commission ("Commission") under the authority of subsection 1 of Ontario Regulation 88/96 made under the *Ministry of Health Act*.

1. Any hospital that is the subject of a direction of which the notice is given, and any other person or organization, may make written submissions to the Commission within thirty (30) days of the notice. The Commission expects that the hospital(s) to which the notice is given will involve any other person or organization affected in any submissions made by the hospital(s).
2. The Commission, on written application or on its own initiative, may consider an extension of the time within which submissions may be made. If any hospital, or any other person or organization, seeks such an extension, the application for such extension shall be submitted to the Commission within ten (10) days after the notice, giving reasons, not exceeding the limit set out in Paragraph 4.2, that may persuade the Commission to permit such excess; under no circumstances will oral representations be permitted on this issue. Within ten (10) days after receipt of such application, the Commission will advise the applicant of its decision on such application.
3. Any person or organization, other than a hospital that is the subject of a direction of which the notice is given, seeking to make representations to the Commission shall identify the person or organization making the representations, and shall include a concise statement not exceeding the length set out in Paragraph 4.2 establishing the reasons why the Commission should consider the representations of that person or organization; the submission of such a person or organization shall otherwise conform to these Guidelines.
4. Submissions shall conform to the following:
 - 4.1 The title page shall include the full legal name of the organization, and the name, full address, postal code, telephone and FAX numbers of the person with whom the Commission may correspond;
 - 4.2 A summary of not exceeding 325 words shall be included, setting out the significant points that are addressed in the submission;

4.3 The following specifications shall be observed:

Font:	12 point
Page Size:	8 ½ " x 11", single sided
Margins:	1" on all sides
Line Spacing:	1½
Maximum Pages:	20 including summary (Paragraph 4.2), plus title page
No. of Copies:	15 copies to be submitted

4.4 The submission shall be divided into sections to address separately the representations related to:

Data and Analysis
Direction and Advice of the Commission, and any other matter;

and may otherwise be divided as the submitter considers appropriate.

4.5 Appendices are not encouraged, but if submitted, each must include a summary conforming to the limits set out in Paragraph 4.2; it is the responsibility of the hospital, or other person or organization, submitting the representation, to ensure the accuracy of the summary.

5 The Commission, on written application or on its own initiative, may consider an extension to the limits on the number of pages. If a hospital or other person or organization considers that, for the Commission to understand the point or points sought to be made, it is essential to exceed the maximum limits prescribed, the application for such excess shall be submitted to the Commission within ten (10) days after the notice, giving reasons, not exceeding the limit set out in Paragraph 4.2, that may persuade the Commission to permit such excess; under no circumstances will oral representations be permitted on this issue. Within ten (10) days after receipt of such application, the Commission will advise the applicant of its decision on such application.

6 The Commission, on written application or on its own initiative, may consider oral representations; where application is made to have the Commission consider oral representations, that application must:

6.1 be made in the written submission noted in Paragraph 1;

6.2 contain a summary of the point(s) that the applicant wishes to make in the oral representations;

- 6.3 identify the person who will be the spokesperson for the applicant;
- 6.4 include the certificate of the spokesperson stating how much time (expressed in hours or fractions of an hour) the spokesperson estimates will be required for the oral representation; generally, the Commission will not permit more than one hour for oral representations unless convinced that such limitation will not afford the applicant sufficient time to identify the point(s) in issue;
- 6.5 satisfy the Commission that the applicant has a real and substantial interest;
- 6.6 satisfy the Commission that the point(s) set out in writing is/are not capable of adequate understanding without oral representations;

unless the Commission otherwise orders, such oral representations, if permitted, will be limited to the points raised in the written submission. The Commission will issue directions as to the conduct of any such hearing if, as and when such a hearing is permitted.

- 7. Any matter to be decided under these Guidelines may be decided by one or more members of the Commission.
- 8. Subject to subsection 6 (5) of the *Public Hospital Act*, the Commission may extend or abridge in any particular case the time limits referred to in these Guidelines.

Revised March 1997

Health Services Restructuring Commission
56 Wellesley Street West, 12th Floor
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